

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 7 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 60477

County of Ada.

Registration District No.

City of Boise.

Primary Registration District No.

Local Registrar's No. 34

(No. St. Lukes Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME DOLLIE Kester.

(a) Residence. No. Boise, Idaho. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female. 4. COLOR OR RACE White. 5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 13th 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min. 0 0 0 0 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho. (State or country)

10. NAME OF FATHER Frank J. Kester.

11. BIRTHPLACE OF FATHER (city or town) Grand Junction (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Marna Marie Taylor

13. BIRTHPLACE OF MOTHER (city or town) Buffalo (State or Country) Wyoming

14. Informant Frank J. Kester.

(Address) Idaho Bldg., Boise, Idaho.

15. Filed 2/15/1928 Laura McDonald Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 13th 1928

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 17, 1927, to Feb 13, 1928

that I last saw her alive on Feb 12, 1928

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature delivery - albumenuria of pregnancy.

(duration) yrs. 7 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. J. M. Davis, M. D. 2/14/28, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Morris Hill Cemetery Boise

2/14/28

20. Undertaker Wm. McBratney.

Address Boise, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED FEB 18 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S60494**

PLACE OF DEATH

County of **BANNOCK**
City of **POCATELLO**

Registration District No. **28**
Primary Registration District No. **2461**
(No. **GENERAL HOSPITAL**)

Local Registrar's No. **5196**

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **INFANT BLANCHARD**(a) Residence. No. **St.**

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX **MALE** 4. COLOR OR RACE **WHITE** 5. Single, Married, Widowed, or Divorced (write the word) **SINGLE**

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) **JAN. 6, 28**

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
STILLBORN

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **POCATELLO, IDAHO**
(State or country)10. NAME OF FATHER **E. D. BLANCHARD**11. BIRTHPLACE OF FATHER (city or town) **LOBAN, UTAH**
(State or Country)12. MAIDEN NAME OF MOTHER **HAZEL E. WHEELER**13. BIRTHPLACE OF MOTHER (city or town) **CLIFTON IDAHO**
(State or Country)14. Informant **E. D. BLANCHARD**(Address) **POBIN IDAHO**15. Filed **1-6**, 19**28**

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

JAN. 6 19**28**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1-6 19**28** to **1-6** 19**28**

that I last saw him alive on **1-6** 19**28**and that death occurred, on the date stated **Stillborn** m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY

difficult forced delivery of fetus coming head.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? **no** Date ofWas there an autopsy? **no**

What test confirmed diagnosis?

(Signed) **W. W. Brothers** M. D.
1-6 19**28** (Address) **Pocahontas**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

POBIN, IDAHO **JAN. 7, 1928**

20. Undertaker

Address

ARTHUR W. HALL **POCATELLO, IDA.**

STATION RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

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RECEIVED MAR 10 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 60743

PLACE OF DEATH
County of Latah
City of Butte

Registration District No. 39
Primary Registration District No. 2-087

Local Registrar's No. S

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stuebner (Houston)

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 4 Hrs. da. How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

1. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X
6. DATE OF BIRTH (month, day and year) _____
7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work as Sten
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2-4-1928
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 2-4-1928 to 2-4-1928
that I last saw him alive on 2-4-1928
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Myocardial - 6 mos. Inj -
Heart
(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) _____
(duration) yrs. mos. ds.

18. Where was disease contracted
If not at place of death? _____
Did an operation precede death? no Date of _____
Was there an autopsy? no
What test confirmed diagnosis? _____
(Signed) Dr. Jennings, M. D.
2-4-1928 (Address) Butte, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

9. BIRTHPLACE (city or town) (State or country) Butte Idaho
10. NAME OF FATHER Sam C. Houston
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Marie Kuder
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Butte Ida
14. Informant Sam C. Houston
(Address) Butte Ida
15. Filed 2-4, 1928 J. H. Murphy
Registrar

19. Place of Burial, Cremation, or Removal Butte Ida Date of Burial 2/4 1928
20. Undertaker Johnson Address Butte Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc.; when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

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Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **61332**

S

PLACE OF DEATH

County of **Canyon**
City of **Nampa**

Registration District No. **7**

Primary Registration District No. **1006**
Mercy Hospital

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. **52**2. FULL NAME **Infant son of Mr And Mrs J.R.Haugan**(a) Residence. No. **High School Add.** St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) **Apr 29 1928**

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **Nampa Idaho**
(State or country)

10. NAME OF FATHER **J.R.Haugan**

11. BIRTHPLACE OF FATHER (city or town) **Chicago**
(State or Country)

12. MAIDEN NAME OF MOTHER **Grace Kliest**

13. BIRTHPLACE OF MOTHER (city or town) **Iowa**
(State or Country)

14. Informant **J.R.Haugan**

(Address) **Nampa Idaho**

15. Filed **5-4**, 19 **28** **May** **1928** **Perby**
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **April 29 1928**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **4-29**, 19**28**, to **4-29**, 19**28**,
that I last saw h. **S** alive on **S**, 19**28**.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born (Dead at birth)
(Cause Central separation placenta)

(duration) _____ yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? **no** Date of _____Was there an autopsy? **no**

What test confirmed diagnosis?

(Signed) **H.P. Bullock**, M. D.**4/30**, 19**28** (Address) **Nampa**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Nampa Idaho**4/30/28 19**

20. Undertaker

Address

Fred K. Robinson**Nampa, Ida.**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1928
PLACE OF DEATH

County of Madison
City of Rexburg

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 100
Primary Registration District No. 2178

DO NOT WRITE IN THIS SPACE

State File No. S61455

Local Registrar's No. 16

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Westover

(a) Residence. No. West Main St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Babe.</u>
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of <u>Babe.</u>		
6. DATE OF BIRTH (month, day and year) <u>April 16, 1928</u>		
7. AGE Years <u>0</u>	Months <u>0</u>	Days <u>0</u>
If LESS than 1 day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Babe.</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

9. BIRTHPLACE (city or town) Rexburg, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER <u>Lorin Westover</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Idaho.</u>
12. MAIDEN NAME OF MOTHER <u>Ethel Anona Virgin.</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Utah.</u>

14. Informant Lorin Westover
(Address) Box 163, Rexburg, Idaho.

15. Filed 4/16, 1928

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 16, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1928, to April 16, 1928, that I last saw him alive on April 16, 1928, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
For tox died in uterus.

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Eclampsia of mother
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of _____

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) John L. Rich, M. D.
4-16-28, 1928 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rexburg, Idaho.
Date of Burial 4/16/28 19

20. Undertaker W. B. Eckersell
Address Rexburg,

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAY 7 1928 CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Quincy*City of *Malad*Registration District No. *26*Primary Registration District No. *2069*

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Herbert Thomas Stratton*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *51512*Registered No. *18*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

Apr. 3 - 1928
(Month) (Day) (Year)

7. AGE

Stillborn
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Malad Idaho

10. NAME OF FATHER

Robert C. Stratton

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Sylvia Thomas Stratton

13. BIRTHPLACE OF MOTHER

(State or Country)

Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Wm. Thomas

(Address)

Malad Idaho

15.

Filed

4/30

19

28

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 3 - 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Apr. 3 - 1928 to Apr. 3 - 1928*that I last saw him *no later* alive *at* 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

*Slow poisoning probably
cause of sleep. No
difficulty to sleep. and slow*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Idaho Apr. 4 - 1928

20. UNDERTAKER

ADDRESS

J. Guy Benson Malad Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

RECEIVED MAY 18 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **61620 S**

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28Primary Registration District No. 2161(No. Pocatello General Hosp.)Local Registrar's No. 5259

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Troupe(a) Residence. No. Pac Gen Hosp St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) April 12, 19287. AGE Stillborn Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello, Ida
(State or country)10. NAME OF FATHER Roger I. Troupe11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Wilder Blinck13. BIRTHPLACE OF MOTHER (city or town) Kansas
(State or Country)14. Informant R. D. Rucker
(Address) Pocatello, Idaho15. Filed Apr 12, 1928 J. H. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12, 1928
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 12, 1928 to April 12, 1928that I last saw him alive Stillborn, 1928

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? NoDid an operation precede death? No Date of _____Was there an autopsy? NoWhat test confirmed diagnosis? No(Signed) W. W. Brotherson, M. D.
April 12, 1928 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pocatello, Idaho Date of Burial April 12, 192820. Undertaker McHann & Co Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PARENTS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meningés, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED JUN 16 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **61672** **S**

PLACE OF DEATH

County of BANNOCK
City of POCATELLO

Registration District No.

Primary Registration District No. 1-1-1

Local Registrar's No.

(No. GENERAL HOSPITAL)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME INFANT ROCK

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. Single, Married, Widowed, or Divorced (write the word) SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) JUNE 8, 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
STILL BORN

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) POCATELLO, IDA.
(State or country)10. NAME OF FATHER RUSSELL H. ROCK11. BIRTHPLACE OF FATHER (city or town)
(State or Country) WASHINGTON12. MAIDEN NAME OF MOTHER LOIS FIFIELD13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) WESTON IDA.14. Informant RUSSELL H. ROCK
(Address) ROCKLAND, IDAHO.15. Filed 6/12, 1928

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

JUNE 8 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19
that I last saw him alive on 19

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Cranial Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. Roell M. D.6/8/28 19 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

ROCKLAND, IDAHO. 6/9/1928

20. Undertaker

ARTHUR W. HALL POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PARENTS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

1102

RECEIVED MAY 18 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 61941**

PLACE OF DEATH

County of PauliCity of CarmenRegistration District No. 41Primary Registration District No. 2116

Local Registrar's No. _____

(No, _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Not named

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m. 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____6. DATE OF BIRTH (month, day and year) 5/9/28 - 7³⁰ AM.7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Seven

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Boyle Creek - Pauli Idaho
(State or country)

10. NAME OF FATHER

Lea Vance Cooper

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

Heilsville Wis.

12. MAIDEN NAME OF MOTHER

Margaret Goddard

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

Boyle Creek Idaho

PARENTS

14.

Informant

(Address)

Annie M Cooper Carmen Idaho

15.

Filed

5/10 - 1928Chas F. Hammer

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 9 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Scarlet fever -
caused by mother's own

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? _____Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) Chas F. Hammer, M. D.May 7 1928 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Salmon Cemetery 5/9 - 1928

20. Undertaker

Address

John C. Shively SalmonMARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED JUL 14 1928 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County of Madison.
City of Rexburg.

Registration District No. 100
Primary Registration District No. 2178

DO NOT WRITE IN THIS SPACE
State File No. 62308

Local Registrar's No. 38

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Grover.

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Babe.

5a. If married, widowed, or divorced
HUSBAND of Babe.
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 22 1928

7. AGE Years 0 Months 0 Days 0 If LESS than 1 day _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Babe.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Rexburg, Idaho.
(State or country)

10. NAME OF FATHER Raymond Grover

11. BIRTHPLACE OF FATHER (city or town) Idaho.
(State or Country)

12. MAIDEN NAME OF MOTHER Kate Browning.

13. BIRTHPLACE OF MOTHER (city or town) Idaho.
(State or Country)

14. Informant Raymond Grover
(Address) Thornton, Idaho R.1

15. Filed 6/22, 1928 J. E. Scherell
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June 22, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22, 1928, to June 22, 1928
that I last saw him alive, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Steebom

(duration) yrs. mos. ds.
CONTRIBUTORY Strangled umbilical cord
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? _____

(Signed) June 22, 1928 (Address) Rexburg, Idaho. M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Archer, Idaho. Date of Burial 6/23/28 19____

20. Undertaker W. E. Scherell Address Rexburg

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

202

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S 62779**

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
(No. General Hospital)

Local Registrar's No. 78

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Glenn

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 9-4-28

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell Idaho
(State or country)

10. NAME OF FATHER Roy Glenn

11. BIRTHPLACE OF FATHER (city or town) Fruitvale Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Hazel M. Fuller

13. BIRTHPLACE OF MOTHER (city or town) Cambridge Ida
(State or Country)

14. Informant Roy Glenn
(Address) Cambridge

15. Filed 9-5- 1928 - John L. Case
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 4-28

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9/3, 1928, to 9/3, 1928
that I last saw him alive on 9/3, 1928

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Montgomery M. D.

9/3, 1928 (Address) Caldwell

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Cambridge Ida Date of Burial 9-5-28 19

20. Undertaker Paul L. Case Address Caldwell Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 5 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 63027**

PLACE OF DEATH

CERTIFICATE OF DEATH

County of.....

Registration District No. 117

City of.....

Primary Registration District No. 2196

Local Registrar's No. 59

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME No Name

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

June 9 - 1928

7 AGE

Years

Months

Days

1 If LESS than
day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Burley, Id

10 NAME OF FATHER

Geo. Dufree

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Idaho

12 MAIDEN NAME OF MOTHER

Beatha Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Idaho

14 Informant

(Address)

Geo Dufree
Burley Id

15 Filed Aug 8, 1928

Dr H H Butler
Regist

16 DATE OF DEATH

June
(Month)

9
(Day)

1928
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 19....., to 19.....

that I last saw h..... alive on 19.....

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still-born - asphyxiated
cord tied about neck

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. The D.

7/10, 1928 (Address) Burley, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Burley Id

June 1928

20. Undertaker

Address

Geo Dufree

Burley, Id

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

REC'D OCT 3 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 63070**

PLACE OF DEATH

County of Boone
City of Boone

Registration District No. 30
Primary Registration District No. 1051
(No. Boone)

Local Registrar's No. 122

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Foley

(a) Residence. No. Mullan Lane St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6 DATE OF BIRTH (month, day and year) Aug 28, 1925

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Boone
(State or country)

10 NAME OF FATHER John A Foley

11 BIRTHPLACE OF FATHER (city or town) Boone
(State or country)

12 MAIDEN NAME OF MOTHER Anna Steiner

13 BIRTHPLACE OF MOTHER (city or town) Boone
(State or country)

14 Informant Mrs Nora Foley
(Address) Boone

15 Filled 9/4 19 28 D. G. Brennan Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Boone Aug 28 19 28
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Still born fetus - 5 mo. development

(duration) yrs. mos. ds.

CONTRIBUTORY Small box in mother
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? No

What test confirmed diagnosis? John A Foley

(Signed) Aug 28 19 28 (Address) Boone

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Catholic Cemetery Date of Burial 8/29 19 28

20 Undertaker C. A. A.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 13 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **S63180**

PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.

(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME

(a) Residence. No.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed,
or Divorced (write the word)5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)14. Informant
(Address)

15. Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 3, 1928, to Sept. 5, 1928.

that I last saw him alive on

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated umbilical cord.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signature)

Sept 5, 1928 (Address) Filer, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL

19. Place of Burial, Cremation, or Removal

Date of Burial

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED OCT 15 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **S 63190**

PLACE OF DEATH

County of Washington Registration District No. _____
City of Wenatchee Primary Registration District No. _____

Local Registrar's No. 10

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Crawford

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stillborn

6 DATE OF BIRTH (month, day and year) Sept. 22 1928

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Idaho
(State or country)

10 NAME OF FATHER Newton Crawford

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Susan Smith

13 BIRTHPLACE OF MOTHER (city or town) Wash.
(State or country)

14 Informant Newton Crawford
(Address) Wenatchee, Idaho

15 Filed Sept 20, 1928 M. L. Kamm
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 22 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Still born, due to toxemia of pregnancy with albuminuria
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) F. Schmidt M. D.
Sept 23, 1928 (Address) Wenatchee, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation or Removal Freeport Cemetery Date of Burial 9-22 1928

20 Undertaker L. B. Northaus Address Wenatchee Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

1057 9-30

W F Howard

RECEIVED OCT 18 1928

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.

S63245

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5388

(No. Fort Hall)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant A F Cutler

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male 4. COLOR OR RACE White 5. Single Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 9-30th 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Fort Hall (State or country)

10. NAME OF FATHER A F Cutler

11. BIRTHPLACE OF FATHER (city or town) Mc Camar Ida (State or Country)

12. MAIDEN NAME OF MOTHER Ethel Weber

13. BIRTHPLACE OF MOTHER (city or town) Humboldt Iowa (State or Country)

14. Informant A F Cutler (Address) Fort Hall

15. Filed 10/5, 19 28 J F Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 30 28
(Month) (Day) (Year)

17. HEREBY CERTIFY, That I attended deceased from Sept 20, 19 28, to Sept 30, 19 28

that I last saw h Still born, 19 28

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Still born
Asphyxia
10 minutes delay in birth of boy
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed Clinical

(Signed) W F Howard M. D.

10/3, 19 28 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt View Date of Burial 10-1st 28

20. Undertaker Schunacker & Beasley Address City

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

64168

State File No.

RECEIVED JAN 5 1929

PLACE OF DEATH

County of Proterus

Registration District No. 20

Local Registrar's No. 189

City of Pound Blaine

Primary Registration District No. 1051

(No. Home Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Island

(a) Residence. No. 102 Indiana St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec 27, 1928

7 AGE Years Months Days If LESS than 1 day, 2 hrs. or 0 min.
0 0 0 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pound Blaine
(State or country) Idaho

10 NAME OF FATHER P. J. Island

11 BIRTHPLACE OF FATHER (city or town) Sweden
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Mooney

13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant P. J. Island
(Address) Pound Blaine

15 Filed 12/29, 1928 W. D. Dregg
Registrar P. M. S.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 27 19 28
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Still born infant, dead probably 4 days prior to delivery
(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. D. Dregg M. D. (Address) Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Forest Cemetery Date of Burial 12/28 19 28

20. Undertaker P. B. Mooney Address Pound Blaine

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 19 1929
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64362 S

County of BANNOCK
City of POCATELLO
Registration District No. 2161
Primary Registration District No. 2161
(No. POCATELLO GENERAL HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 5454

2. FULL NAME INFANT BENNER
(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX MALE 4. COLOR OR RACE WHITE 5. Single, Married, Widowed, or Divorced (write the word) SINGLE

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) NOV. 6, 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min. STILL BORN

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work NONE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) POCATELLO, IDAHO
(State or country)

PARENTS

10. NAME OF FATHER A. B. BENNER

11. BIRTHPLACE OF FATHER (city or town) URBANA, OHIO.
(State or Country)

12. MAIDEN NAME OF MOTHER LULA CHRISTENSEN

13. BIRTHPLACE OF MOTHER (city or town) BEAR LAKE UTAH.
(State or Country)

14. Informant A. B. BENNER
(Address) 250 - WAYNE AVE. Poca. Ida.

15. Filed 11/14, 1928
 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 6, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,
that I last saw h. alive on , 19 ,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Dr. Mrs. Gustafson
 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
 (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) 11/14, 1928 M. D.
(Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal MOUNTAIN VIEW Date of Burial NOV. 8, 1928
20. Undertaker ARTHUR W. HALL Address POCATELLO,

SEP 26 2006

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

10 B

RECEIVED JAN 19 1929

PLACE OF DEATH

County of BANNOCK
City of POCATELLOSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 28
Primary Registration District No. 2161
(No. LYNN BROS. HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 64366 SLocal Registrar's No. 54582. FULL NAME ELMA COX(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>FEMALE</u>	4. COLOR OR RACE <u>WHITE</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>SINGLE</u>
-------------------------	----------------------------------	--

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) NOV. 15, 1928

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work NONE INFANT
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) POCATELLO,
(State or country)10. NAME OF FATHER JOHN COX11. BIRTHPLACE OF FATHER (city or town) S. L. C. UTAH
(State or Country)12. MAIDEN NAME OF MOTHER JEANNETTE ALLEN13. BIRTHPLACE OF MOTHER (city or town) ILLINOIS
(State or Country)14. Informant JOHN COX
(Address) 810 - So. 4th Ave.15. Filed 11/16, 1928
J. Young
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 15, 1928
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from NOV 15, 1928, to NOV 15, 1928
that I last saw her alive on NOV 15, 1928
and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia
St. Louis
(duration) yrs. mos. ds.CONTRIBUTORY Mother Coubae
(Secondary) Pelvis
about 6 mo (duration) yrs. mos. ds.18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? apnea(Signed) J. Young M. D.NOV 16, 1928 (Address) Pocateello
Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

MOUNTAIN VIEW CEMETERY NOV. 16 1928

20. Undertaker Address

ARTHUR W. HALL POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

1105

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

64367 S

State File No.

PLACE **RECEIVED JAN 19 1928**
County of **BANNOCK**
City of **POCATELLO**

Registration District No.

Primary Registration District No.

Local Registrar's No. **5459**(No. **LYNN BROS. HOSPITAL**)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **JEANNETTE COX**

(a) Residence. No.

St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

FEMALE

4. COLOR OR RACE

WHITE5. Single, Married, Widowed,
or Divorced (write the word)**SINGLE**5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

Nov. 15, 1928

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.**NONE INFANT**(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)**POCATELLO.**

10. NAME OF FATHER

JOHN COX11. BIRTHPLACE OF FATHER (city or town)
(State or Country)**S.L.C. UTAH.**

12. MAIDEN NAME OF MOTHER

JEANNETTE ALLEN13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)**ILLINOIS**

14. Informant.

JOHN COX

(Address)

810 - So. 4th AVE.

15. Filed

11/16, 1928

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov.**15,****1928**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

NOV 15 -**1928,****to NOV 15 -****1928**

that I last saw her alive on

Nov 15 -**1928**

and that death occurred, on the date stated above, at

4:30 P.m.

The CAUSE OF DEATH* was as follows:

premature birth.**about 6 months duration**

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)**mother pelvis
contracted**

(duration)

yrs.

mos.

ds.

18. Where was disease contracted

if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

What test confirmed diagnosis?

apparatus

(Signed)

Dr. J. M. D.**11-16, 1928** (Address)**POCATELLO**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

MOUNTAIN VIEW CEMETERY Nov. 16, 1928

20. Undertaker

Address

ARTHUR W. HALL POCATELLO

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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RECEIVED APR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

65470

S

State File No.

Local Registrar's No.

PLACE OF DEATH
County of Boyle
City of Lewiston

Registration District No. 96Primary Registration District No. 1009(No. White Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Downing(a) Residence. No. 0121 - 27th St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single; Married; Widowed; or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) 10/3/1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant (Address)

15. Filed Nov 10, 1928 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 3 1928 to Oct 3 1928that I last saw him Still born 1928and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Still-born
No cause can be elicited.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Edgar R. White M. D.

(Signed)

10/4 1928 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Lewiston Idaho 10/4 1928

20. Undertaker

Address

Prover-Wann & Lewiston, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

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Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

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20 B

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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RECEIVED APR 4 1929

PLACE OF DEATH

County of Nez PerceCity of Lewiston
 STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH
Registration District No. 96Primary Registration District No. 1409(No. St. Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. _____

2. FULL NAME Viola May Miller(a) Residence. No. Astoria Wash. St. _____

Length of residence in city or town where death occurred. yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Infant5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6. DATE OF BIRTH (month, day and year) Stillborn7. AGE Premature Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Lewiston, Idaho
(State or country)10. NAME OF FATHER Adolph Miller11. BIRTHPLACE OF FATHER (city or town) _____
(State or Country)12. MAIDEN NAME OF MOTHER Ella Miller13. BIRTHPLACE OF MOTHER (city or town) _____
(State or Country)14. Informant _____
(Address) _____15. Filed Nov 10, 1928 Susan E. Prince
Registrar

DO NOT WRITE IN THIS SPACE

State File No. 65486

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 29 1928
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 29, 1928, to Oct 29, 1928
that I last saw him alive on Oct 29, 1928
and that death occurred, on the date stated above, at 7:30 A.M.
The CAUSE OF DEATH* was as follows:Premature Birth
5 1/2 months gestation
(duration) _____ yrs. _____ mos. _____ ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted _____
if not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? noWhat test confirmed diagnosis? none(Signed) Ed. H. Baggett, M. D.
Oct 31, 1928 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston, Idaho Date of Burial 10/29 192820. Undertaker Vassar Funeral Home Address Lewiston, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

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Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

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2015

MARGIN RESERVED FOR BINDING

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RECEIVED JUL 3 1928

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **S66580**

1. PLACE OF DEATH
County of Gooding
City of Hagerman

Registration District No. 21
Primary Registration District No. not
(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Gilbert Hastings

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH May 11 - 1928
(Month) (Day) (Year)

7. AGE Still Born IF LESS than 1 day how many Still Born or min. ?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Hagerman Ida
(State or Country)

10. NAME OF FATHER John Gilbert Hastings

11. BIRTHPLACE OF FATHER Miss
(State or Country)

12. MAIDEN NAME OF MOTHER Jae Kennicott

13. BIRTHPLACE OF MOTHER Chicago
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John G Hastings
(Address) Hagerman

15. Filed May 11 1928 R N Greene
Local Registrar

16. DATE OF DEATH May 11 - 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Still Born 19 19
that I last saw him alive on 19
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E. Kennicott M. D.
19 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Hagerman Ida DATE OF BURIAL May 11 1928

20. UNDERTAKER None ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

713 106 201 147
PLACE OF BIRTH

RECEIVED FEB 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S B

CERTIFICATE OF BIRTH

County of Ada
City of Boise
No. 1617-76-17th St.
Salvation Army
(If born in hospital or institution
give name.)

Registration District No. 2 State File No. 158369

Prim. Registration District No. 100 Local Registrar's No. 12

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <input checked="" type="checkbox"/>	and	Number in order of birth <u>1</u>	Legiti- mate? <input checked="" type="checkbox"/>	Date of Birth <u>Jan. 6</u>	19 <u>28</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth one (a) Born alive and now living none

Born alive but now dead none Stillborn one

FATHER	MOTHER
FULL NAME <u>William Palmer</u>	FULL MAIDEN NAME <u>Anna Irene Adams</u>

Residence (Usual place of abode) Idaho Buhl

If nonresident, give place and State Idaho Idaho

Color or race white Age at last Birthday 16 white Age at last Birthday 14

Birthplace does not know (Years) Cedar Hill Idaho (Years)

Occupation school boy (City and State or Country) School girl (City and State or Country)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 2:30 A. M.
on the date above stated.

(Signature) Clifford M. N.

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Paula McDonald

Filed 1/14/28 19 Paula McDonald
Registrar.

RECEIVED FEB 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **60190**

PLACE OF DEATH

County of Ada.City of Boise.Registration District No. 2Primary Registration District No. 1004(No. Salvation Army Rescue Home.)Local Registrar's No. 12

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Adams.(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male.

4. COLOR OR RACE

White.5. Single, Married, Widowed,
or Divorced (write the word)Single.5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

January 6th 1928

7. AGE

Years

Months

Days

If LESS than 1 day,

----- hrs. or
min.000

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.None.(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

10. NAME OF FATHER

William Palmer.11. BIRTHPLACE OF FATHER (city or town).
(State or Country)Don't Known.

12. MAIDEN NAME OF MOTHER

Anna Adams.13. BIRTHPLACE OF MOTHER (city or town).
(State or Country)Ceder Hill, Idaho.14. Informant Pearl Allen.

(Address)

Boise, Idaho.15. Filed 1/7/28, 1928 Paula McDonald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 6th 1928

(Month)

(Day)

19
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 6, 1928 to Jan 6, 1928that I last saw her alive on Jan 6 - 1928and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Still birthCONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? W Date of Was there an autopsy? WWhat test confirmed diagnosis? (Signed) , M. D.
1/7/28, 1928 (Address) Boise, Idaho.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

County Cemetery 1-7-28 1928

20. Undertaker

Address

Wm. McBratney.Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bingham

City of Blackfoot

No. 515-218-006-575 St.

County

(If born in hospital or institution
give name.)

RECEIVED FEB 14 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 121 State File No. 158444

Prim. Registration District No. 1007 Local Registrar's No. 30

FULL NAME OF CHILD Unnamed Van Fossen.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>January 18</u> 19 <u>28</u>
				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead 0 Stillborn One

FATHER

FULL NAME Eugene Earl Van Fossen.

Residence (Usual place of abode) Blackfoot, Ida.

If nonresident, give place and State

Color or race White Age at last Birthday 36 (Years)

Birthplace Oklahoma (City and State or Country)

Occupation Farmer

MOTHER

FULL MAIDEN NAME Iva Viola Van Fossen

Residence (Usual place of abode) Blackfoot

If nonresident, give place and State

Color or race White Age at last Birthday 30 (Years)

Birthplace Kansas (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11:55 P. M.
on the date above stated.

(Signature) E. E. Fosse

(Physician or XXXXX)

Address Blackfoot, Idaho.

Filed Feb 24 19 28 Mr. W. L. Fosse

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

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RECEIVED FEB 14 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **60230**

PLACE OF DEATH

County of BinghamCity of Blackfoot.Registration District No. 121Primary Registration District No. 1007Local Registrar's No. 16(No. County Hospital, W. Judicial St.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Unnamed Nan Fossen.(a) Residence. No. Blackfoot, Idaho R.F.D.No.4. St.(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) January, 1928		
7. AGE Stillborn	Years Months Days	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9. BIRTHPLACE (city or town) Blackfoot, Idaho. (State or country)		

OF FATHER

Eugene Earl Van Fossen.PLACE OF FATHER (city or town) **Kansas.**
or CountryEN NAME OF MOTHER **Iva Viola Van Fossen**PLACE OF MOTHER (city or town) **Oklahoma**
or Country**Blackfoot, Idaho.**p. 19 28 **Mr Eugene E Van Fossen**
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January, 1928
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Jan. 28, 1928, to Jan. 29, 1928
that I last saw ~~XXXXXX~~ **Jan. 1928**
and that death occurred, on the date stated above, at **11.55 P.**The CAUSE OF DEATH* was as follows:
**Stillborn. Premature 5 Months
in utero. Following automobile
accident, due to traumatism**

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? **5 to 7 Mi. W
of Blackfoot, Idaho**Did an operation precede death? **No** Date ofWas there an autopsy? **No** ObservationWhat test confirmed diagnosis? **Observation**
(Signed) **E. E. Van Fossen** M. D.
Jan. 28, 1928 (Address) **Blackfoot, Idaho***State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.19. Place of Burial, Cremation, or Removal **Van Fossen, farm.** Date of Burial **Jan. 19**20. Undertaker **Eugene Earl Van Fossen** Address **Blackfoot**MARGIN RESERVED FOR BINDING
WITH UNFADING INK—THIS IS A PERMANENT RECORD
should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
plain terms, so that it may be properly classified. Exact statement of OCCUPA-
tion on back of certificate.N. 11/18/28
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A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

693-122 014 497
PLACE OF BIRTH

RECEIVED FEB 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Canyon

City of Baldwell

No. P. F. N.

St. Registration District No. 3

State File No. 158507

Hospital

Primary Registration District No. 2005 Local Registrar's No. 15

FULL NAME OF CHILD Baby Wittell

(Certificate of no value without full name of child)

Sex of Child male Twin Triplet or other? and Number in order of birth 1
(To be answered only in event of plural births)

Legitimate? yes Date of birth January 2, 1928
(Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 6

Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Kyle Elvis Wittell
RESIDENCE Caldwell, Idaho
COLOR white AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Nampa, Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Chittie Eleanor Dix
RESIDENCE Caldwell, Idaho
COLOR white AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Fort Collins, Colorado
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn 5:00 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature)

C. R. Whittenberger
Osteopath
(Physician or midwife)

Address

Baldwell, Idaho

Filed

1-22-1928 John H. Meyer
Registrar.

Registrar.

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PLACE OF BIRTH

STATE OF OHIO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____
 Primary Registration District No. _____
 State File No. _____

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of child _____
 Date of birth _____
 Time of birth _____
 Place of birth _____
 (To be answered only in case of plural births)

What antiseptical solution was used in event?

Number of child of this mother, including present birth _____
 Name of child of this mother now living, including present birth _____

FATHER		MOTHER	
NAME	RESIDENCE	NAME	RESIDENCE
FULL NAME		FULL NAME	
MAIDEN NAME		MAIDEN NAME	
COLOR		COLOR	
AGE AT LAST BIRTHDAY (in years)		AGE AT LAST BIRTHDAY (in years)	
BIRTHPLACE		BIRTHPLACE	
OCCUPATION		OCCUPATION	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____

When there was no attending physician or midwife, then the father, householder or mother, make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. (Give names added from a supplemental report)

(Physician or midwife)

(Signature)

ADDITIONAL

FILED

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **60260**

PLACE OF DEATH

County of Canyon
City of Baldwell

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 7

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Wittell(a) Residence. No. R.F.D. St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 22, 1928

7. AGE Years Months Days If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 0(b) General nature of industry, business, or establishment in which employed (or employer) 0(c) Name of employer 09. BIRTHPLACE (city or town) Baldwell, Idaho
(State or country)10. NAME OF FATHER Kyle Elzie Wittell11. BIRTHPLACE OF FATHER (city or town) Nampa, Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Clutha Eleanor Dix13. BIRTHPLACE OF MOTHER (city or town) Fort Collins, Colorado
(State or Country)14. Informant C.R. Whittenberger
(Address) Baldwell, Idaho15. Filed 1-22, 1928 John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 22 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

January 22, 1928 to January 22, 1928
That I last saw him alive on January 22, 1928

and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? NO Date of _____Was there an autopsy? NOWhat test confirmed diagnosis? Clinical

(Signed) C.R. Whittenberger, M.D.
Jan., 1928 (Address) Baldwell, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Home Jan. 22, 1928

20. Undertaker

Address

Father & friends Baldwell, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED FEB 8 1928
OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County Franklin
City of Preston

No. 243 St. 021-799

(If born in hospital or institution
give name.)

Registration District No. 27 State File No. 158570

Prim. Registration District No. 2118 Local Registrar's No. 2

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin <u>Yes</u> or Triplet <u>No</u> or other? <u>No</u>	Number in order of birth <u>1st</u>	Legitimate? <u>Yes</u>	Date of birth <u>Jan 28 1928</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓

Number of child of this mother, including present birth 2 (a) Born alive and now living Two

Born alive but now dead ✓ Stillborn Two

FATHER	MOTHER
FULL NAME <u>B C Butters</u>	FULL MAIDEN NAME <u>Laura Griffith</u>

Residence (Usual place of abode) Preston Idaho

If nonresident, give place and State ✓

Color or race White Age at last Birthday 28 (Years)

Birthplace Clarkston Utah (City and State or Country)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4:45 P M.
on the date above stated.

(Signature) Thos B Holder

Physician
(Physician or midwife)

Address Preston Idaho

Filed Feb 1 1928 B C Butters

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-30

RECEIVED FEB 8 1928

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Franklin

Registration District No. 27

City of Weston

Primary Registration District No. 2119

State File No. 60302

Local Registrar's No. 2

If death occurs away from usual residence, give facts called for under special information.

(No. _____ St.)

Stillborn

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE & SINGLE, MARRIED, WIDOWED OR DIVORCED

White

Single

(Write the word)

5. DATE OF BIRTH

Jan. 29, 1928

(Month)

(Day)

(Year)

6. AGE

0

Yrs.

0

Mos.

0

ds.

0

IF LESS than 1 day, how many hrs. or min.?

0

7. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business or establishment in which employed (or employer)

8. BIRTHPLACE

(State or Country)

Weston, Idaho

9. NAME OF

Father

B. C. Butters,

10. BIRTHPLACE

OF FATHER

Clarkston, Utah

(State or Country)

11. MAIDEN NAME

OF MOTHER

Laura Griffeth

12. BIRTHPLACE

OF MOTHER

Clarkston, Utah

(State or Country)

13. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. C. Butters,

(Address)

Weston, Idaho

14.

Filed

Feb. 4

1928

A. R. Cutler

Local Registrar

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH

Jan

29

1928

(Month)

(Day)

(Year)

16. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on

19

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

5 1/2 Months Gestation.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Thos. A. Holder

M. D.

19

(Address)

Weston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

17. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

18. PLACE OF BURIAL OR REMOVAL

Weston, Idaho

DATE OF BURIAL

Jan. 29, 1928

19. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED FEB 8 1928 STATE OF IDAHO
County of Franklin DEPARTMENT OF PUBLIC WELFARE
City of Merton Idaho BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
No. 243129 021-799 St. 158571
(If born in hospital or institution
give name.) Registration District No. 27 State File No. 158571
Prim. Registration District No. 2119 Local Registrar's No. 3

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin <u>2</u> { and { Number in order of birth <u>1</u> Triplet or other? <u>no</u> (To be answered only in event of plural births)	Legitimate? <u>yes</u>	Date of birth <u>Jan 28</u> 19 <u>28</u> (Month) (Day) (Year)
--------------------------	--	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? no

Number of child of this mother, including present birth 4 (a) Born alive and now living Two
Born alive but now dead. no Stillborn Two

FATHER	MOTHER
FULL NAME <u>B. B. Butters</u>	FULL MAIDEN NAME <u>Laura Griffith</u>
Residence (Usual place of abode) <u>Merton Idaho</u>	Residence (Usual place of abode) <u>Merton Idaho</u>
If nonresident, give place and State <u>✓</u>	If nonresident, give place and State <u>✓</u>
Color or race <u>white</u> Age at last Birthday <u>28</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>28</u> (Years)
Birthplace <u>Clarkston Utah</u> (City and State or Country)	Birthplace <u>Clarkston Utah</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>House Keeper</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4 45 P M.
on the date above stated.

(Signature) Thos B. Holder
Physician
(Physician or midwife)

Address Merton Idaho
Filed Feb. 1 1928 R. K. Cullis
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

THESE ARE NOT A RIPOST—NOT AN EVIDENCED BY THE TENDENTLY SET BY THE COURT. THE COURT IS NOT TO BE TAKEN INTO ACCOUNT IN THIS CASE. IT IS NOT TO BE TAKEN INTO ACCOUNT IN THIS CASE. IT IS NOT TO BE TAKEN INTO ACCOUNT IN THIS CASE.

"There were no attending physicians in the room," said the father, "and I was not in the room. A nurse was called and she called a doctor and he came and he said that the child is not that badly hurt and that he would take care of it. He said that he would take care of it and that he would take care of it."

on the date above stated.

and this child, who was a stillborn

ЗАДАНИЕ ПО КАБРИНУ: ПРИНЦИПЫ ЧО ЭТАПОДРО

CONFIDENTIAL

City and State of Canada

18-00000

RECEIVED JUL 19 1964

Age of last birthday

(Copy of 1900 - [illegible] at [illegible])

4. non-existent. The above and 2nd

2012-01-01 00:00:00

St. John's, N. B., 10/10/1914

Exhibits: 1-10, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 8

REF ID: A66541

ASHTON

Number 10 of this report, containing the following information:

(a) Born alive and now living

What is the purpose of this document?

1007015009.

67803

SECRET

11/11/11

20-8731
File

NAME OF CHILD

1997

It is estimated that the total number of people in the world who are illiterate is about 1 billion.

Prim. Registration District No. 1000

of the state of the nation

RECEIVED
BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

13871

FORM V. S. No. 5-25 M. 1-19.

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
DEPARTMENT OF PUBLIC HEALTH

1. PLACE OF DEATH

County of FranklinCity of Weston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27Primary Registration District No. 2119

(No. _____ St.)

State File No. 60301Local Registrar's No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stillborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

(Write the word)

6. DATE OF BIRTH

Jan. 29, 1928

(Month) (Day) (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds. 0IF LESS than 1 day how many
0 hrs. or
0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Weston, Idaho

10. NAME OF

Father B. C. Butters,

11. BIRTHPLACE

OF FATHER (State or Country) Clarkston, Utah

12. MAIDEN NAME

OF MOTHER Laura Griffeth

13. BIRTHPLACE

OF MOTHER (State or Country) Clarkston, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B.C. Butters
(Address) Weston, Idaho

15.

Filed Feb. 4 1928 C. R. Butler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan (Month)29 (Day)1928 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19that I last saw him alive on 19,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

5 1/2 Months Gestation

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. A. Holder M. D.19 (Address) Weston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Weston, Idaho

DATE OF BURIAL

Jan. 29, 1928

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED FEB 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

158746

County of Minidoka

City of Rupert

No. 696-202 034-799 St.

(If born in hospital or institution
give name.)

Registration District No. 19 State File No.

Prim. Registration District No. 2015 Local Registrar's No. 6

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in case of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Jan 2</u> (Month) (Day) (Year) <u>1928</u>
----------------------------	--	-------	--------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME James A. Fifield

Residence (Usual place of abode) Rupert

If nonresident, give place and State _____

Color or race white Age at last Birthday 31
(Years)

Birthplace Montana
(City and State or Country)

Occupation Shoe Canner

MOTHER
FULL MAIDEN NAME Katherine Griffing

Residence (Usual place of abode) Rupert

If nonresident, give place and State _____

Color or race white Age at last Birthday 29
(Years)

Birthplace Missouri
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 6:25 P. M.
on the date above stated.

(Signature) Leland Truitt M.D.

(Physician or midwife)

Address Rupert, Ida.

Filed 2-2 1928 E. H. Moore

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

N. B.—In case of twins, then one child
 shall be living with
 and the number of other

*Where there was no attending physician
 or midwife, then the father, grandfather,
 etc., should make this report. A newborn
 child is one that neither breathes nor
 shows other evidence of life after birth.

I hereby certify that I attended the birth of this child, who was: Female
 on the date above stated. (Signature) [Signature]
 (Physician or midwife)
 Address [Address]
 Filed [Date] Registrar [Signature]

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 (City and State or Country) [City and State or Country]
 Residence (Usual place of abode) [Residence (Usual place of abode)]
 Color of race [Color of race] Age at last birth [Age at last birth]
 It nonresident, give place and State [It nonresident, give place and State]
 Residence (Usual place of abode) [Residence (Usual place of abode)]
 NAME [NAME] FULL NAME [FULL NAME] MOTHER [MOTHER]
 Number of child of this mother, including present birth [Number of child of this mother, including present birth]
 If first pregnancy was used to prevent [If first pregnancy was used to prevent] [Optional Abortion]
 Child of [Child of] and in order [and in order] to be numbered only in case of [to be numbered only in case of]
 Date of birth [Date of birth] (Month) [Month] (Year) [Year]
 If still-born, mention the word "Stillborn" for cause of death.

FULL NAME OF CHILD [FULL NAME OF CHILD]
 Birth Name [Birth Name] District No. [District No.] Local Institution No. [Local Institution No.]
 Registration Number No. [Registration Number No.]
 STATE OF [STATE OF]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of, OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 4 1928

 STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 61055

Local Registrar's No. 21

 PLACE OF DEATH
 County of Montana
 City of Rupert

 CERTIFICATE OF DEATH
 Registration District No. 19
 Primary Registration District No. 2015

 (If death occurred in a hospital or institution, give its name instead of street and number.)
 2. FULL NAME Still Born

 (a) Residence. No. _____ St. _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Child

 5a If married, widowed, or divorced
 HUSBAND of _____
 (or) WIFE of _____

6 DATE OF BIRTH (month, day and year)

 7 AGE Years 0 Months 0 Days 0 If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

 14 Informant Jessie Fifield
 (Address) Rupert, Idaho

 15 Filled 2-12, 1928 Ed E. Blum
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 1928
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1928 to Jan 2, 1928
 that I last saw him allys on Still Born, 1928
 and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born
Unable to ascertain cause - had been down probably 2 days
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Delores H. H. H. M. D._____, 19____ (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation or Removal

Dele Idaho Date of Burial Jan 3 1928
 20 Undertaker W. G. Goodman Address Rupert Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

415-726-039 367

PLACE OF BIRTH

RECEIVED FEB 6 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of Power

City of Power Falls

No. _____ St.

CERTIFICATE OF BIRTH

158829

Registration District No. 25 State File No. _____

Prim. Registration District No. 2072 Local Registrar's No. 12

(If born in hospital or institution give name.)

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Jan</u> <u>26</u> <u>19 28</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	---------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth One (a) Born alive and now living 0

Born alive but now dead 0 Stillborn One

FATHER

FULL NAME Caron Davis

Residence (Usual place of abode) Power Falls Ida

If nonresident, give place and State 0

Color or race white Age at last Birthday 39 (Years)

Birthplace Mo (City and State or Country)

Occupation Baker

MOTHER

FULL MAIDEN NAME Else L. Cope

Residence (Usual place of abode) Power Falls Ida

If nonresident, give place and State 0

Color or race white Age at last Birthday 29 (Years)

Birthplace Kan (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at _____ M.
on the date above stated.

(Signature) Wm. L. Langan W. H. Gore

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed 2-2 1928 Genevieve North

Registrar.

THE SECRET

SECRET

GOING TO NEW YORK

104

[illegible]

1994

1. The first part of the document is a letter from the author to the reader, explaining the purpose of the study and the methods used. The letter is dated 1968 and is addressed to the reader.

THE UNIVERSITY OF CHICAGO

(attached to exhibit)

2. 10/1/77

RECEIVED
FEB 9 1968
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 6 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 50417

County of Power

Registration District No. 23

City of American Falls

Primary Registration District No. 20/2

Local Registrar's No. 2

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still born

(a) Residence. No. _____ St. _____

(Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) _____

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Jan 26th - 1928

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) American Falls
(State or country) Idaho

10 NAME OF FATHER Arson Darr

11 BIRTHPLACE OF FATHER (city or town) Mo
(State or country)

12 MAIDEN NAME OF MOTHER Else L Cope

13 BIRTHPLACE OF MOTHER (city or town) Kansas
(State or country)

14 Informant ✓
(Address) ✓

15 Filed 2-4, 1928 Genevieve Roth
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 26 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Still born

CONTRIBUTORY (Secondary) _____

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Dr. V. G. Logan, M. D.
_____, 19____ (Address) Amer. Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal American Falls, Ida Date of Burial Jan-30 1928

20. Undertaker Family
Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical-state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED MAR 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

B

County of Ada

City of Boise

No. 266-210.001-296 St.

Registration District No. 2

State File No. 158950

Hospital St. Lukes

Primary Registration District No. 1004

Local Registrar's No. 60

FULL NAME OF CHILD Joan Sower

(Certificate of no value without full name of child)

Sex of Child

Female

Twin
Triplet
or other?

— }

and {

Number
in order
of birth

— }

Legiti-
mate?

yes

Date of
birth

Feb 10th

1928

(Month) (Day) (Year)

What bactericidal solution was used in eyes? Stillbirth

Number of child of this mother, including present birth 1st

Number of child of this mother now living, including present birth 0

FULL
NAME

FATHER

Vern L. Sower

RESIDENCE

Boise - RD 4

COLOR

White

AGE AT LAST
BIRTHDAY

26
(Years)

BIRTHPLACE

Minnesota

OCCUPATION

Oil Salesman

FULL
MAIDEN
NAME

MOTHER

Arda K. Brown

RESIDENCE

Boise RD 4

COLOR

White

AGE AT LAST
BIRTHDAY

28
(Years)

BIRTHPLACE

New Zealand

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Boys alive Stillborn at 10:18 P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

J. M. Taylor
M.D. Boise 100

(Physician or midwife)

Address

Boise, Idaho

Filed

2281

1928

Gula McMoran

Registrar.

Registrar.

Give names added from a supplementary report. Shows other witnesses of the crime. It is not that neither father nor son should make this report. A witness or mother, then the father, however. When there was no attending physician.

I hereby certify that I attended the birth of the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

10-10-68

BIRTHPLACE

AGE AT LAST COLOR AGE AT LAST COLOR

RESIDENCE

NAME	FATHER	MOTHER
RAIDEN	RAIDEN	RAIDEN
RAIDEN	RAIDEN	RAIDEN

[Faint, illegible text at the bottom of the page]

To be answered only in event of fatal injury

SECRET

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

Witness Registration District No. _____

100-100000-100000

19 JUN 68

DEPARTMENT OF THE ARMY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 7 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 604748

County of Ada
City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. St. Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 32

2. FULL NAME Infant Souver.

(a) Residence. No. R 4. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb-10-1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise Idaho (State or country)

10. NAME OF FATHER Vere J. Souver

11. BIRTHPLACE OF FATHER (city or town) Minnesota (State or Country)

12. MAIDEN NAME OF MOTHER. Freda Brown

13. BIRTHPLACE OF MOTHER (city or town) New Zealand (State or Country)

14. Informant Vere J. Souver (Address) Boise Idaho R. D. # 4

15. Filed 2-13-1928 Paula McLoune Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 10 1928 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 10 1928, to Feb 10 1928

that I last saw him alive on Feb 10 1928

and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Probable of cord in labor -
Heart had stopped beating
before delivery -

(duration) yrs. mos. ds.

CONTRIBUTORY cord around neck at
(Secondary) beginning of labor. Head in
Pelvic inlet (forceps required)

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. M. Taylor M. D.
Feb 11 1928 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial
Morris Hill Cemetery Feb. 13 192820. Undertaker Address
Hummel & Trebs Boise Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcema, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of AdaCity of BoiseNo. R3 St.22124001381(If born in hospital or institution
give name.)

RECEIVED MAR 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

158683

Registration District No. 8 State File No.Prim. Registration District No. 2008 Local Registrar's No. 15

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
ChildMTwin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?yesDate of
birthFeb 24

(Month)

(Day)

1928
(Year)What prophylactic was used to prevent Ophthalmia Neonatorum? Credé SolutionNumber of child of this mother, including present birth 1(a) Born alive and now living P

Born alive but now dead

Stillborn

yes - prematureFULL
NAMEFloyd Bishop

FATHER

FULL
MAIDEN
NAMEMaudie Champion

MOTHER

Residence (Usual place of abode)

Boise R3

Residence (Usual place of abode)

Boise R3

If nonresident, give place and State

Ida

If nonresident, give place and State

Ida

Color or race

W

Age at last Birthday

32

(Years)

Color or race

W

Age at last Birthday

39

(Years)

Birthplace

Ida

(City and State or Country)

Birthplace

Ida

(City and State or Country)

Occupation

Ida

Occupation

Hw

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12:10 a. M.
on the date above stated.

(Signature)

John Baack

(Physician)

Address

Boise Ida

Filed

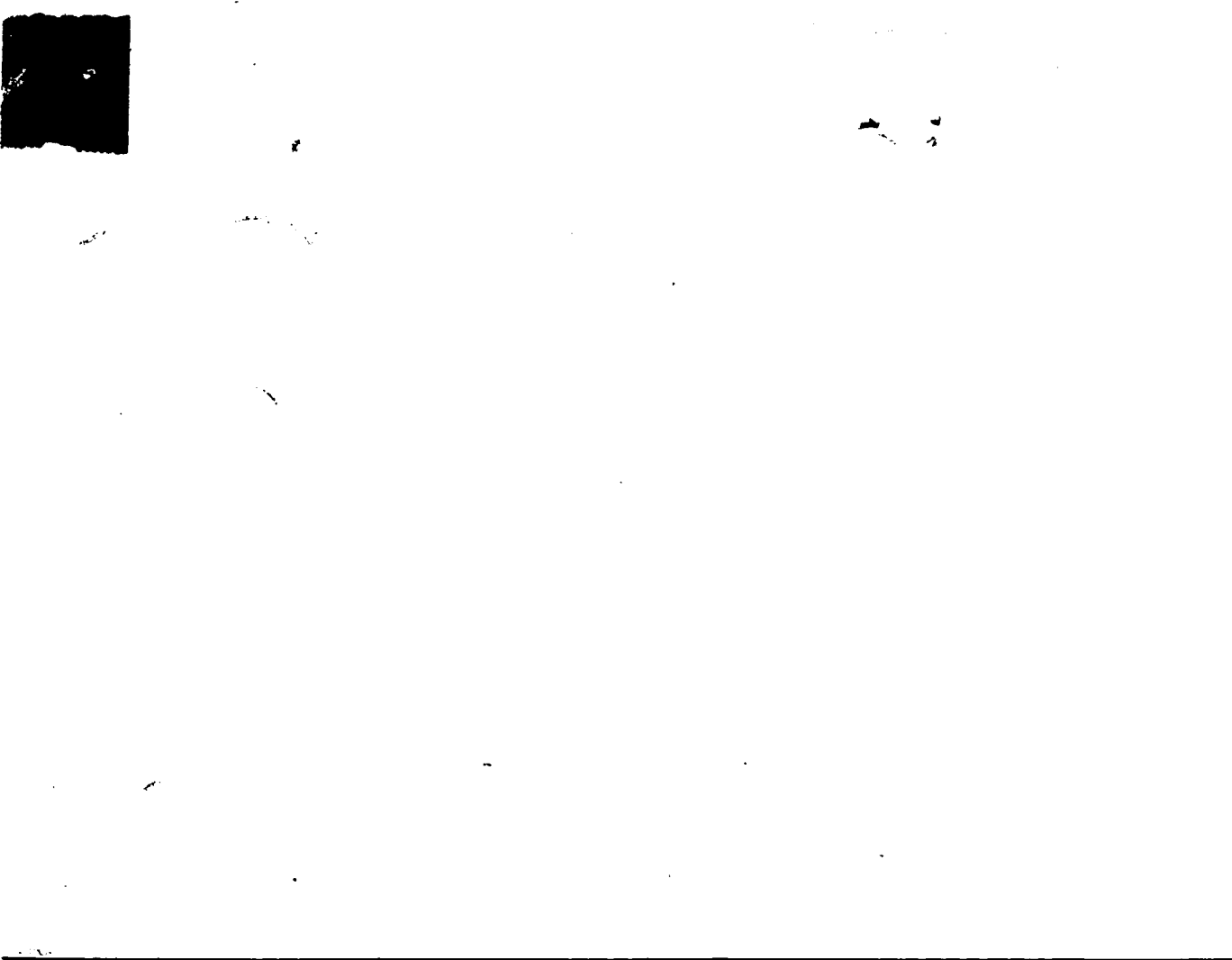
3/2

1928

Paula McDonald

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO

RECEIVED MAR 7 1928
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 60467

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004

Local Registrar's No. 51

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Bishop

(a) Residence. No. 2418 - N. 22nd St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., (If nonresident give city or town and State) yrs. mos. ds. if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 2-24/28

7. AGE Years Months Days If LESS than 1 day, min. hrs. or
Still Birth.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

10. NAME OF FATHER Floyd Bishop

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Neb.

12. MAIDEN NAME OF MOTHER Maud Champlin.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Idaho.

14. Informant Floyd Bishop.
(Address) Boise, Idaho.

15. Filed 2/24/28 1928 Julia McElroy
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 24 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Feb 24 1928, to Feb 24 1928
that I last saw him alive on same date, 1928
and that death occurred, on the date stated above, at 10:00 m.

The CAUSE OF DEATH* was as follows:

Death occurred several days
before birth - cause unknown.
mother gives history of a fall about
2 weeks ago (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Brink M. D.

Feb 24 1928 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Morris Hill Cemetery 7/24/28.

20. Undertaker Address

Ed McBratney Boise Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF RECEIPT FEB 18 1928

STATE OF IDAHO

S

County of Blaine

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

City of Paradise

No. 19-113-203-168 St.

CERTIFICATE OF BIRTH

159032

Paradise General Hospital

Registration District No. 28

State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 2161

Local Registrar's No. 8505

FULL NAME OF CHILD

Still born

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

M

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate

Yes

Date of
birth

January 13 1928

What prophylactic was used to prevent Ophthalmia Neonatorum?

10% Argysol

Number of child of this mother, including present birth

2

(a) Born alive and now living

Born alive but now dead

0

Stillborn

1

FATHER
FULL
NAME

Noel L. Harwood

Residence (Usual place of abode)

Ray, Idaho

If nonresident, give place and State

Color or race

wh

Age at last Birthday

30
(Years)

Birthplace

Michigan

(City and State or Country)

Occupation

Farmer

MOTHER
FULL
MAIDEN
NAME

Helen Johnson

Residence (Usual place of abode)

Ray, Idaho

If nonresident, give place and State

Color or race

wh

Age at last Birthday

24
(Years)

Birthplace

Seattle, Washington

(City and State or Country)

Occupation

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

Born alive
Stillborn

at 3:15

9 A. M.

(Signature)

D. C. Ray

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

(Physician or midwife)

Address

Paradise, Idaho

Filed

7/1 1928

Ray

Registrar.

State of New York
County of New York

CHINA TO STRIKE JAPANESE

1945

1. The name of the person who was used to receive the information is [redacted]

[illegible]

_____ (check to sign letter) _____
_____ (check to sign letter) _____

[illegible][illegible]

There were no attending physician

(Signature)

as the date was stated

[illegible]

100-443887-100

RECEIVED FEB 18 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 60495

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161

Local Registrar's No. 5197

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Harwood

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 13, 1928

7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, hrs. or _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work man.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello, Ida
(State or country)10. NAME OF FATHER W. R. Harwood11. BIRTHPLACE OF FATHER (city or town) Minn.
(State or Country)12. MAIDEN NAME OF MOTHER Helen Johnson13. BIRTHPLACE OF MOTHER (city or town) Seattle
(State or Country) Washington14. Informant W. R. Harwood
(Address) Ray, Idaho15. Filed Jan 13, 1928
Registrar J. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 13 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1928 to 1-13 1928
that I last saw him live on _____, 1928

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born
due to thrombosis
mother
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY

(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? D.C. Ray, M. D.(Signed) 1-13 1928 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pocatello, Ida Date of Burial Jan 13 192820. Undertaker McHendry & Co. Address Pocatello

Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

RECEIVED MAR 9 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSCERTIFICATE OF BIRTH **S** 159082County of BinghamCity of BlackfootNo. 267. 102 dols. St.Registration District No. 121.

State File No.

Hospital 253105 006-614Primary Registration District No. 1007Local Registrar's No. 71FULL NAME OF CHILD Richard Keloo

(Certificate of no value without full name of child)

Sex of Child

MaleTwin
Triplet
or other?

}

and {

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?yesDate of
birthFeb 51928

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1Number of child of this mother now living, including present birth 1FULL
NAME

FATHER

Stacy Keloo

RESIDENCE

Springfield Idaho

COLOR

White

AGE AT LAST

BIRTHDAY

(Years)

4

BIRTHPLACE

Orem

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Ernest Good

RESIDENCE

Springfield

COLOR

White

AGE AT LAST

BIRTHDAY

(Years)

42

BIRTHPLACE

OCCUPATION

OremHousewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at Blackfoot Idaho on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

H. W. Mitchell

(Physician or midwife)

Address

Blackfoot, Idaho

Filed

March 7 1928

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

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10/10/50

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 9 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 60518

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonneville Registration District No. 121
City of Bluffton, Idaho Primary Registration District No. 1007

Local Registrar's No. 19

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard Kelso(a) Residence. No. 267 W. Idaho St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year)

7 AGE _____ Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Bluffton, Idaho
(State or country)10 NAME OF FATHER Clay Kelso11 BIRTHPLACE OF FATHER (city or town) Penn
(State or country)12 MAIDEN NAME OF MOTHER Irma Wald13 BIRTHPLACE OF MOTHER (city or town) Penn
(State or country)

14 Informant Clay Kelso
(Address) Springfield, Idaho

15 Filed Feb 6 1928 Malcolm E. Tatum
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb (Month) 5 (Day) 1928 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 5 1928, to Feb 5 1928

that I last saw him alive on Feb 5 1928
and that death occurred, on the date stated above, at 2. G. m.

The CAUSE OF DEATH* was as follows:

Barb. ch. for ventilation

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted _____
If not at place of death?Did an operation precede death? no Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Microscopic

(Signed) Malcolm E. Tatum M. D.
Feb 6 1928 (Address) Bluffton, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Springfield, Idaho Date of Burial 2-6 1928

20 Undertaker E. J. Park Address Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

3/3 004 000-213
PLACE OF BIRTH

RECEIVED FEB 18 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Bonneville
City of Idaho Falls
No. L. I. O. L. St.

Registration District No. 23 State File No. 159219

(If born in hospital or institution give name.)

Prim. Registration District No. 2140 Local Registrar's No. 10

FULL NAME OF CHILD Call, Stillborn (6 months fetus)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Jan.</u> <u>4</u> <u>1928</u> (Month) (Day) (Year)
--------------	---	---	---------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 7 (a) Born alive and now living 4
Born alive but now dead 2 Stillborn 1

FATHER
FULL NAME Call, Chas J
Residence (Usual place of abode) Idaho Falls
If nonresident, give place and State
Color or race white Age at last Birthday 38 (Years)
Birthplace Idaho Falls (City and State or Country)
Occupation merchant

MOTHER
FULL MAIDEN NAME Watson, Alice
Residence (Usual place of abode) Idaho Falls
If nonresident, give place and State
Color or race white Age at last Birthday 34 (Years)
Birthplace Idaho Falls (City and State or Country)
Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. Stillborn at 12:15 9 M.

(Signature) [Signature]

(Physician or midwife)

Address Idaho Falls

Filed Jan 10 19 28 C. J. [Signature]
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

404

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED FEB 21 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
159289

County of Cassia

City of Becla

No. _____ St.

845-122-016-316

(If born in hospital or institution
give name.)

Registration District No. 117 State File No. _____

Prim. Registration District No. 2195 Local Registrar's No. 22

FULL NAME OF CHILD

Stillbirth ✓

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate? yes

Date of
birth

Jan 22 1928
(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Hyrum Ellis Huntman

Residence (Usual place of abode) Becla

If nonresident, give place and State _____

Color or race white Age at last Birthday 41

(Years)

Birthplace Nevada

(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Joan M^c Lays

Residence (Usual place of abode) Becla

If nonresident, give place and State _____

Color or race white Age at last Birthday 40

(Years)

Birthplace Utah

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn ✓ at H. O. P. M.
on the date above stated.

(Signature) Lulu Hagen, M.D.

(Physician or midwife)

Address Rupert, Idaho

Filed Feb 26 1928 Wm F H Guller

Wm F H Guller Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH		MAR 8 1928		STATE OF IDAHO						
County of Clearwater		DEPARTMENT OF PUBLIC WELFARE								
City of Pocatello Idaho		BUREAU OF VITAL STATISTICS								
		CERTIFICATE OF BIRTH		S 159310						
No. 719231018744		Registration District No. 90		State File No.						
(If born in hospital or institution give name.)		Prim. Registration District No. 2168		Local Registrar's No. 17						
FULL NAME OF CHILD Stillbirth (Baby Garrett)										
(If stillborn, substitute the word "Stillbirth" for name of child)										
Sex of Child	Female	Twin Triplet or other?	and	Number in order of birth	Legitimate?	Date of birth	1	31	1928	
				(To be answered only in event of plural births)	yes	(Month)	(Day)	(Year)		
What prophylactic was used to prevent Ophthalmia Neonatorum?										
Number of child of this mother, including present birth 3						(a) Born alive and now living one				
Born alive but now dead none						Stillborn two				
FATHER			MOTHER							
FULL NAME Thomas Elmo Garrett			FULL MAIDEN NAME Florence Millicent Judd							
Residence (Usual place of abode) Pocatello			Residence (Usual place of abode) Pocatello							
If nonresident, give place and State			If nonresident, give place and State							
Color or race white			Age at last Birthday 35			Color or race white			Age at last Birthday 28	
Birthplace Collins Mo.			(City and State or Country)			Birthplace Pocatello Idaho			(City and State or Country)	
Occupation Farming						Occupation Housewife				

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive} at 5.45 P. M. on the date above stated.

(Signature)

W. T. Robertson
M.D.

(Physician or midwife)

Address

Pocatello Idaho

Filed

Mar 1 1928

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the said County, at the City of New York, this 1st day of May, 1910.

CLERK OF THE COUNTY OF NEW YORK

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

150310

DATE OF BIRTH

REPORT OF BIRTH NO. 150310
 DISTRICT NO. 1
 CITY OF NEW YORK
 NAME OF CHILD JOHN J. BROWN
 SEX MALE
 DATE OF BIRTH APRIL 15 1910
 TIME OF BIRTH 10:30 AM
 PLACE OF BIRTH AT HOME
 NAME OF MOTHER MARY J. BROWN
 NAME OF FATHER JOHN J. BROWN
 ADDRESS 1234 5th Ave. New York City

NAME	DATE OF BIRTH	SEX	TIME OF BIRTH	PLACE OF BIRTH	NAME OF MOTHER	NAME OF FATHER	ADDRESS
<u>JOHN J. BROWN</u>	<u>APRIL 15 1910</u>	<u>MALE</u>	<u>10:30 AM</u>	<u>AT HOME</u>	<u>MARY J. BROWN</u>	<u>JOHN J. BROWN</u>	<u>1234 5th Ave. New York City</u>
Residence (Usual place of abode)	It was born at	Color of hair	Color of eyes	Birthplace (Usual place of abode)	It was born at	Color of hair	Color of eyes
<u>1234 5th Ave. New York City</u>	<u>AT HOME</u>	<u>BROWN</u>	<u>BROWN</u>	<u>1234 5th Ave. New York City</u>	<u>AT HOME</u>	<u>BROWN</u>	<u>BROWN</u>
Birthplace (Usual place of abode)	It was born at	Color of hair	Color of eyes	Birthplace (Usual place of abode)	It was born at	Color of hair	Color of eyes
<u>1234 5th Ave. New York City</u>	<u>AT HOME</u>	<u>BROWN</u>	<u>BROWN</u>	<u>1234 5th Ave. New York City</u>	<u>AT HOME</u>	<u>BROWN</u>	<u>BROWN</u>

STATE OF NEW YORK
 COUNTY OF NEW YORK
 I hereby certify that I attended the birth of this child, who was
 (Signature) JOHN J. BROWN
 (Physician or midwife)
 Address 1234 5th Ave. New York City
 *When there was no attending physician or midwife, then the father, mother, or other person who was present at the birth of the child is the best qualified person to give the information required in this form.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 60611

PLACE OF DEATH
County of Clearwater
City of Fragers

Registration District No. 90
Primary Registration District No. 2168

Local Registrar's No. 8

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Garrett (Stillbirth)

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. Yrs. mos. ds. How long in U. S., if of foreign birth? Yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) ✓

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) 1/31/28

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
✓ ✓ ✓ ✓ ✓

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. ✓(b) General nature of industry, business, or establishment in which employed (or employer) ✓(c) Name of employer ✓9. BIRTHPLACE (city or town) Fragers Ida
(State or country)10. NAME OF FATHER Shos Elmo Garrett11. BIRTHPLACE OF FATHER (city or town) Collins
(State or Country) Mo.12. MAIDEN NAME OF MOTHER Florence Millicent Ford13. BIRTHPLACE OF MOTHER (city or town) Fragers Ida
(State or Country)14. Informant ✓
(Address) ✓15. Filed McH 2, 1928 J. M. Fairly
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 31st 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

do not knowCONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted ✓
if not at place of death?Did an operation precede death? no Date of ✓Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. P. Johnston M. D.1/31, 1928 (Address) Fragers Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

19

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED MAR 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Clearwater

City of Elk River

No. 716-222-018-265 St.

Hospital Elk River

FULL NAME OF CHILD Baby Paolini

Registration District No. 91 State File No. 159319

Primary Registration District No. 2168 Local Registrar's No. 167

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>2/ 22/ 1928</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth		Number of child of this mother now living, including present birth	
FULL NAME	FATHER	FULL MAIDEN NAME	MOTHER
<u>Pete Paolini</u>		<u>Irene Swenson</u>	
RESIDENCE		RESIDENCE	
<u>Elk River Idaho.</u>		<u>Elk River, Idaho.</u>	
COLOR	AGE AT LAST BIRTHDAY <u>26</u> (Years)	COLOR	AGE AT LAST BIRTHDAY <u>18</u> (Years)
<u>White</u>		<u>White</u>	
BIRTHPLACE		BIRTHPLACE	
<u>Italy</u>		<u>Deary Idaho.</u>	
OCCUPATION		OCCUPATION	
<u>Lumber Piler</u>		<u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive ☒ Stillborn ☐ at 3.20 AM. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature)

OM. Kuster, M.D.

(Physician or midwife)

Address

Elk River, Idaho

Filed

March 2 1928

Mildred Gandy

Registrar.

Registrar.

PLACE OF BIRTH

STATE OF IOWA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

OFFICE OF THE ATTORNEY GENERAL

Registration District No. _____ State File No. _____

Primary Registrar or District Registrar's No.

REF ID: A66363

(Certificate of no value without full name of child)

(Year) (Month) (Day)

and { } and { }

(The names are given in Latin script.)

(Name) (Month) (Year)

What bacteriological solution was used for the large ni bong new notification label and tag?

Number of child of this mother, including present birth

RENTAL

DATA

SECRET

SECRET

• never Idano.

॥०५॥

et in

BOAHTHSH
11/11/11

NO:TA94000

1914-1915

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(I hereby certify that I attended the birth of this child, who was born on)

on the date above stated.

Other names added from a supplemental report shows other evidence of life after death. It is one of the better practices not to should make this point. A student or friend, read the letter, handwritten. When there was no attending physician.

(Physician or midwife)

279:1A

1000000

18-00000

801

1501

10-10-61

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12 **RECEIVED MAR 6 1928** CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 91
County of _____ Primary Registration District No. 2168
City of _____ (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Pauline

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 60609
Registered No. 39

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant
(Write the word.)

6. DATE OF BIRTH Feb 22 1928
(Month) (Day) (Year)

7. AGE Still born IF LESS than 1 day
_____ yrs. _____ mos. _____ ds. how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Elk River, Idaho

10. NAME OF FATHER

Pete Pauline

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Irene Swenson

13. BIRTHPLACE OF MOTHER

(State or Country)

Deary Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Pete Pauline

(Address)

Elk River, Id

15.

Filed

March 2 1928

Mildred Hambley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 22 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____

that I ~~last~~ ^{never} saw him h.a. alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stillborn - Sixth Month of Gestation

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory Conditions of Acronia and
(Secondary) Polyhydramnios were present

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) O.M. Husted M. D.

Feb. 22 1928 (Address) Elk River, Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

_____ 191____

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital)," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

County of Good

MAR 9

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICSCity of GoodleyNo. 493-208-024-264CERTIFICATE OF BIRTH **S** 159373

Registration District No. State File No.

(If born in hospital or institution
give name.)Prim. Registration District No. 24 Local Registrar's No. 244FULL NAME OF CHILD Rae Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>girl</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>2 - 5 - 1928</u> (Month) (Day) (Year)
--------------------------	---	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? noneNumber of child of this mother, including present birth 4 (a) Born alive and now living 2Born alive but now dead 2 Stillborn 2

FATHER FULL NAME <u>Rex Miller</u>	MOTHER FULL MAIDEN NAME <u>Josephine W. Bodenhofer</u>
---------------------------------------	---

Residence (Usual place of abode) Goodley

If nonresident, give place and State

Color or race white Age at last Birthday 27 (Years)Birthplace Idaho (City and State or Country)Occupation FarmerOccupation Housewife

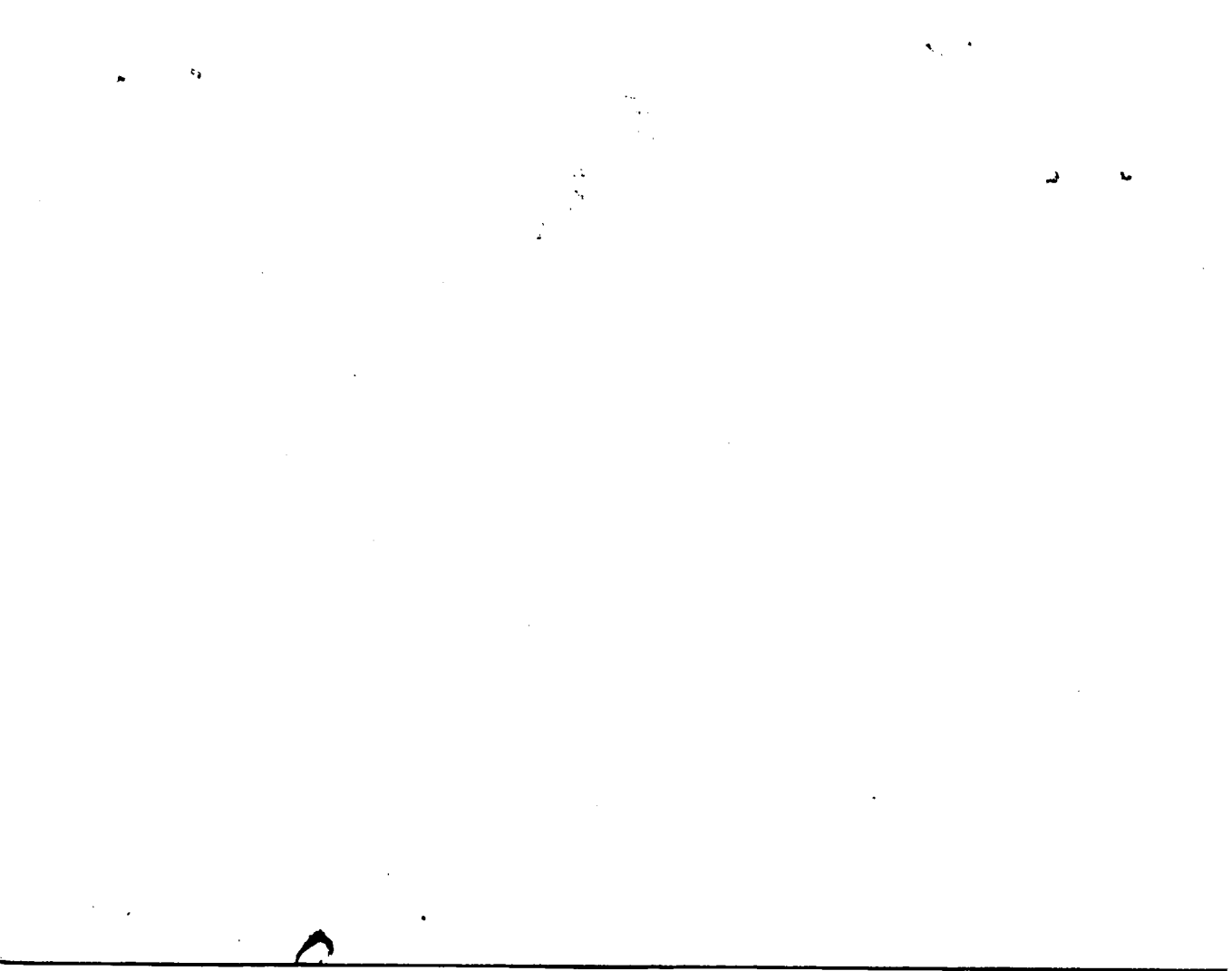
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8:30 A. M.
on the date above stated.(Signature) J. H. Crumwell

(Physician or midwife)

Address Goodley IdFiled 2/39 1928 J. H. Crumwell
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 536 M. 1-16-13

MAR 9 1928

CERTIFICATE OF DEATH.

60629

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Gooding
City of IdahoRegistration District No.
Primary Registration District No. 24
(No. St.)File No. 88
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Shelburne

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

girl

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

Feb 5 1928
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Rex Miller

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Josephine W. Bodenhofer

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Rex Miller
Gooding

15.

Filed

31-28 JH

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 5 1928
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
191... to 191...
that I last saw him alive on 191...
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Shelburne - Gestational
Nephrosis severe
diabetes

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days In the State... yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gooding 2-6-28

20. UNDERTAKER

ADDRESS

Chapman Gooding

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Idaho
City of Kootenai

No. St.

763117 025844

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

7 mos. Julius

Registration District No. 106 State File No. 159388

Prim. Registration District No. 2184 Local Registrar's No. 12

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Jan 17</u> 19 <u>28</u> (Month) (Day) (Year)
--------------------------	---	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth (a) Born alive and now living

Born alive but now dead Stillborn one

FATHER
FULL NAME Louis Pallezian

Residence (Usual place of abode) Kootenai

If nonresident, give place and State

Color or race white Age at last Birthday 39 (Years)

Birthplace Kootenai (City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Maymie H. H. H. H.

Residence (Usual place of abode) Kootenai

If nonresident, give place and State

Color or race white Age at last Birthday 29 (Years)

Birthplace (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 7 a.m.
on the date above stated.

(Signature) J. M. Weber

(Physician or midwife)

Address Kootenai - Idaho

Filed March 1928 J. M. Weber Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Legation District No. 1, 1st Avenue, New York
State, New York

(b)(7) - (D), (b)(7) - (F), (b)(7) - (G), (b)(7) - (H), (b)(7) - (I), (b)(7) - (J), (b)(7) - (K), (b)(7) - (L), (b)(7) - (M), (b)(7) - (N), (b)(7) - (O), (b)(7) - (P), (b)(7) - (Q), (b)(7) - (R), (b)(7) - (S), (b)(7) - (T), (b)(7) - (U), (b)(7) - (V), (b)(7) - (W), (b)(7) - (X), (b)(7) - (Y), (b)(7) - (Z)

(L.A.M.)

Whether of kind of this matter, including Bureau of Prisons (a) _____ (b) _____ (c) _____ (d) _____ (e) _____ (f) _____ (g) _____ (h) _____ (i) _____ (j) _____ (k) _____ (l) _____ (m) _____ (n) _____ (o) _____ (p) _____ (q) _____ (r) _____ (s) _____ (t) _____ (u) _____ (v) _____ (w) _____ (x) _____ (y) _____ (z) _____

[illegible]

State of New York

11 MAY 1964

...to some level, consistent

State the only one, though not in

100-443887-20

(UNCLASSIFIED TO DATE BY [REDACTED])

MENTAL STATE OF ATTENDING PHYSICIAN OF MURDERER.

1. I further certify that I attended the birth of this child, who was born on

(original)

enochia

[illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 18 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 60642

PLACE OF DEATH

County of IsaiahCity of Rocky

CERTIFICATE OF DEATH

Registration District No. 106Primary Registration District No. 2184Local Registrar's No. 250

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still birth - 9 mos. fetus

(a) Residence, No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year) Jan. 17 - 1928

7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, hrs. or min. _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Isaiah (State or country) _____10. NAME OF FATHER Louis Patterson11. BIRTHPLACE OF FATHER (city or town) Kansas (State or Country) _____12. MAIDEN NAME OF MOTHER Maymie Humphill13. BIRTHPLACE OF MOTHER (city or town) Illinois (State or Country) _____14. Informant Louis Patterson (Address) Rocky15. Filed Jan 17, 1928 J M Verbeekmans Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 17 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows: _____

Probably due to large internal fetal complication pregnancy
still born (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J M Verbeekmans, M. D.Jan 17 1928 (Address) Rocky

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Isaiah Cemetery Date of Burial Jan 17 1928
20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc.; Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

143716-029
RECEIVED MAR 1 1928MAIL OR DELIVER THIS CERTIFICATE TO YOUR LOCAL REGISTRAR,
NOT TO THE STATE BOARD OF HEALTH.

PLACE OF BIRTH

Washington State Board of Health

County of LatahCity or
Town of Genesee Ids.

Bureau of Vital Statistics

CERTIFICATE OF BIRTH

Record No.

Registered No. 4Registration Dist. No. 62Place of Birth Genesee (near) Ids.

FULL NAME OF CHILD

Stillborn

{ If child is not yet named make supplemental report, as directed.

Sex of Child <u>Male</u>	Twin, Triplet or other? <u>One</u>	and { Number in order of birth? <u>3</u>	Legitimate? <u>Yes</u>	Date of Birth <u>Feb. 16 -</u> , 192 <u>8</u> (Month) (Day) (Year)
--------------------------	------------------------------------	--	------------------------	---

FATHER

Full Name Edward P. Jutte

Residence Genesee, Ids.

Color White Age at last Birthday 31 (Years)

Birthplace (State or Country) Idaho

Occupation Farming

MOTHER

Full Maiden Name Carrie C. Schenck

Residence Genesee, Ids.

Color White Age at last Birthday 31 (Years)

Birthplace (State or Country) Idaho

Occupation Housewife

Number of child of this mother 3Number of children, this mother, now living 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.*

I hereby certify that I attended the birth of this child, who was { born alive } and that it occurred on.....Feb. 16 -, 1928, at 3 P. M.

{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. }

(Signature) Charles P. Bury

(Physician or Midwife)

Give name added from a supplemental report.....

Address LeucutownFiled 2-18, 1928 W. H. Shew

Registrar.

Registrar.

† Indicate which by drawing line through superfluous word.

FOR HYDRA

STANDARD

100

100

100

100

THE BOARD OF HEALTH

CERTIFICATE OF BIRTH

CERTIFICATE OF BIRTH

Place of Birth

Full Name of Child

Child's Name	Sex	Age	Color	Weight	Height	Measurements
John Doe	Male	10	White	150	150	150
Father's Name	Mother's Name	Birth Date	Birth Time	Birth Place	Birth Hospital	Birth Doctor
John Doe	Jane Doe	10/10/10	10:10	New York	St. Mary's	Dr. Smith

Occupation	Education	Religion	Marital Status	Number of Children	Number of Siblings	Other Information
Teacher	High School	Catholic	Married	2	1	None

Signature of Registrar	Signature of Parent	Signature of Doctor	Signature of Midwife	Signature of Nurse	Signature of Other	Signature of Other
John Doe	Jane Doe	Dr. Smith	Ms. Jones	Ms. Brown	Ms. Green	Ms. White

168 223070-251
PLACE OF BIRTHCounty of LemhiCity of Gilmore

No. _____ St. _____

Hospital _____

Full Name of Child

Registration District No. 42Primary Registration District No. 2153STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11—25m-6-15-18

CERTIFICATE OF BIRTH

File No. 159449

Registered No. _____

S

SEX OF CHILD <u>Female</u>	Twin Triplet or other? (To be answered only in case of plural births)	and Number in order of birth	Legiti- mate? <u>yes</u>	DATE OF BIRTH <u>Jan. 23 98</u> (Month) (Day) (Year)
FULL NAME <u>Arthur C. Johnson</u>	FATHER		FULL MAIDEN NAME <u>Ruth Beach</u>	MOTHER
RESIDENCE <u>Gilmore Idaho</u>			RESIDENCE <u>Gilmore Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>30</u> (Years)		COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Mass.</u>			BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Miner</u>			OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth Number of children of this mother now living, including present birth

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn, at 2:30 A.M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Mrs. A. E. Johnson

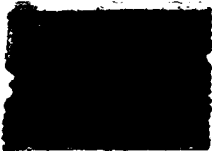
(Physician or midwife)

Given names added from supplemental report

Address _____

Filed _____

Registrar John T. BubbisRegistrar John T. Bubbis



100

101

[The remainder of the page contains extremely faint, illegible text, likely bleed-through from the reverse side of the document.]

FORM V. S. No. 5-25 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
 County of Lemhi on District No. 42
 City of Gilmore Primary Registration District No. 2153
 (No. St.)

File No. 60670
 Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 (Write the word.)

6. DATE OF BIRTH Jan. 23 1908
 (Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day
 how many hrs.
 or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Lemhi, Idaho
 (State or Country)

10. NAME OF FATHER Arthur E. Johnson

11. BIRTHPLACE OF FATHER Mass.
 (State or Country)

12. MAIDEN NAME OF MOTHER Ruth Beach

13. BIRTHPLACE OF MOTHER Idaho
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A. Buehler, M.D.
 (Address) Leadore, Idaho

15. Filled 3/5 28 1908
John A. Buehler, M.D.
 Local Registrar

16. DATE OF DEATH

Jan. 23 1908
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 that I last saw h..... alive on 19.....
 and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Stillborn 7 1/2 months, wgt. 4 lb. length 14 inch.
 (Duration) Yrs..... mos..... ds.

Contributory (Secondary) No Physician or Midwife attended
 (Signature) M. D.
 19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Gilmore, Idaho DATE OF BURIAL 1/23 08

20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Registrar.

1440

10-10-68

DATE OF BIRTH

John J. ...

[illegible]

_____ (a) _____ (b) _____ (c) _____ (d) _____ (e) _____ (f) _____ (g) _____ (h) _____ (i) _____ (j) _____ (k) _____ (l) _____ (m) _____ (n) _____ (o) _____ (p) _____ (q) _____ (r) _____ (s) _____ (t) _____ (u) _____ (v) _____ (w) _____ (x) _____ (y) _____ (z) _____

have will that within a year

SECRET

11/11/54

(show to each legu: secret)

1968-1970

100-443887-1

CONFIDENTIAL

1961-1962

(continued)

1. I am a member of the following organization:

THE DEPT. OF THE ARMY

Journal of Management Education 30(6)

[illegible]

1. The first of these is the fact that the

See also: [Other links](#)

CONFIDENTIAL

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

THE UNIVERSITY OF CHICAGO

(97-01809-42)

1944-1945

2291bA

DATA

*We have no attending physician
to indicate that the patient has
any abnormal condition. A
solid is one that neither practices nor
shows other evidence of life after death.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 61052Local Registrar's No. 18County of Merida Registration District No. 17City of Rupert Primary Registration District No. 2015

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still Born Baby Brown

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced (write the word) Born

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of Still Born

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rupert
(State or country) Idaho10 NAME OF FATHER Clarence T. Brown11 BIRTHPLACE OF FATHER (city or town)
(State or country) New Mexico12 MAIDEN NAME OF MOTHER Reola Aldous13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Idaho14 Informant Mrs. Katie Brown
(Address) Rupert Idaho15 Filed Mar 11, 1928 E. E. Elmer
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) Feb(Day) 9th1928
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Feb 9 - 1928, to _____ 19____.that I last saw h. Still born child 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Brach Presentation - Compression
of umbilical cord

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Leland Truitt, M. D._____, 19____ (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Rupert CemeteryFeb 10 1928

20. Undertaker

Address

W. G. GoodmanRupert

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

K or BLACK Record typewriter ribbon in completing this certificate. This certificate MUST be filed with the R in the district where the birth occurred WITHIN 10 days after the date of birth of the child. Address DIVISION OF VITAL STATISTICS, BOISE, IDAHO.

791-201034-128
Amended 10-27-64

(Be sure the information is complete and accurate)

CERTIFICATE OF BIRTH
STATE OF IDAHO

State File No. 159489
Local Reg. No. 33
Reg. Dist. No. 19

S

1. PLACE OF BIRTH		2. USUAL RESIDENCE OF MOTHER (Where does mother live?)	
a. COUNTY Minidoka		a. STATE Idaho	b. COUNTY Minidoka
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rupert		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rupert	
c. FULL NAME OF (If NOT in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. CHILD'S NAME (Type or print)			
a. (First) (Stillborn - 7½ mo. Gestation)		b. (Middle)	
		c. (Last) Grace	
4. SEX Female	5a. THIS BIRTH SINGLE _____ TWIN <input checked="" type="checkbox"/> TRIPLET _____	5b. IF TWIN OR TRIPLET (This child born) 1st <input checked="" type="checkbox"/> 2nd _____ 3rd _____	6. DATE OF BIRTH (Month) (Day) (Year) Mar. 1, 1928

FATHER OF CHILD

7. FULL NAME		a. (First) Floyd	b. (Middle) I.	c. (Last) Grace
8. AGE (At time of this birth) 33 YEARS	9. BIRTHPLACE (State of foreign country) (City or Town) Kentucky	10. USUAL OCCUPATION Laborer		11. KIND OF BUSINESS OR INDUSTRY

MOTHER OF CHILD

12. FULL MAIDEN NAME		a. (First) Mae	b. (Middle)	c. (Last) Aston
13. AGE (At time of this birth) 32 YEARS	14. BIRTHPLACE (State or foreign country) (City or Town) Idaho	15. CHILDREN PREVIOUSLY BORN TO THIS MOTHER (Do NOT include this child)		
16. INFORMANT'S SIGNATURE OR NAME (Relationship)		a. How many OTHER children are now living? 2	b. How many OTHER children were born alive but are now dead? 1	c. How many children were stillborn (born dead after 20 wks. pregnancy)? 3

I hereby certify that this child was born alive on the date stated above.

17. SIGNATURE E.H. Elmore, M.D.	18. ATTENDANT AT BIRTH M.D. <input checked="" type="checkbox"/> MIDWIFE _____ OTHER (Specify) _____
19. ADDRESS Rupert	20. DATE SIGNED
21. DATE REC'D BY LOCAL REG. 3-3-1928	22. REGISTRAR'S SIGNATURE E.H. Elmore
23. DATE ON WHICH GIVEN NAME ADDED BY _____ Registrar	

FOR MEDICAL AND HEALTH USE ONLY

(This section MUST be filled out)

LENGTH OF PREGNANCY WEEKS	WEIGHT AT BIRTH lbs	Was a standard serological test for syphilis performed? Yes _____ No _____
Approximate date		

LOCAL REGISTRATION OF BIRTHS

Sec. 38-213. All births that occur in the state shall be immediately registered in the districts in which they occur, as hereinafter provided.

Sec. 38-214. SAME: DUTIES OF THE PHYSICIANS AND MIDWIVES. It shall be the duty of the attending physician or midwife to file a certificate of birth, properly and completely filled out, giving all the particulars required by this article, with the local registrar of the district in which the birth occurred, within 10 days after the date of birth; and if there be no attending physician or midwife, then it shall be the duty of the father or mother of the child, nurse, householder, or owner of the premises, having knowledge of such birth, manager or superintendent of public or private institutions in which birth occurred, to notify the local registrar, within 10 days after the birth, of the fact of such birth having occurred. It shall then, in such case, be the duty of the local registrar to secure the necessary information and signature to make proper certificate of birth: Provided, That in cities, the certificate of birth shall be filed at less intervals than 10 days after birth, if so required by municipal ordinances or regulations now in force, or that may hereafter be enacted.

Sec. 38-215. CERTIFICATES OF BIRTH. The certificate of birth shall be filled out as per blanks for that purpose.

Sec. 38-223. * * * * *, any physician or midwife, in attendance upon a case of confinement, or any other person charged with responsibility for reporting births, in the order named in Sec. 38-214 who shall neglect or refuse to file a proper certificate of birth with the local registrar, within the time required by this article, shall be deemed guilty of a misdemeanor, and, upon conviction thereof, shall be fined not less than \$10 nor more than \$300.

MEDICAL REPORT

(Not for certified copies)

(To be used for Crippled Children, Maternal and Child Health Work)

(a) Pregnancy: Complications of.....

.....
.....

(b) Labor: Complication.....

.....
..... Induced?.....

(c) State all operations for delivery.....

(d) Did baby have any:

(1) Congenital Malformation?

Describe:.....

(2) Birth Injury?.....

Describe:.....

(e) Signature of Physician:

IDAHO DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of..... }
County of..... } ss.

Certificate No. 159489

Date Filed.....

The undersigned does solemnly swear that certain facts on the certificate of birth
for unnamed Grace who was stillborn on Mar. 1, 1928
(Name on Original Certificate) (Was Born or Died) (Date of Event)
in Rupert are erroneous or were omitted; and that, to the best of his knowledge, the
(Place of Event)
true facts are shown by..... prepared on..... are:

(Bible Record, Insurance Policy, Etc.)

(Give Date)

FACTS TO BE CORRECTED
("Name," "Birth Date," "Cause of Death," Etc.)

FROM
(As on Original)

TO
(The Correct Facts)

mothers maiden name May Astle May Aston

Subscribed and sworn to before me this 26th day of April, 1928

Signed Frieda R. Maurer
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Notary Public, residing at Idaho - Astle
My commission expires April 7, 1927
(Seal)

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of..... }
County of..... } ss.

[This Affidavit **MUST** Also be Executed.
(See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this..... day of
....., 19.....

Signed.....
(Signature of Any Credible Person)

Notary Public, residing at.....
My commission expires.....
(Seal)

(Street Address, City, State)

Certificate of Membership of another child gives maiden name of mother as Mae Aston, mother of Eva Mae Grace. James H. Gilbert, Bishop in L.D.S. Church Accepted. Jan. 24, 1926 in Kelly Ward, Idaho
Viewed by V. S.

Marriage license gives name as Mae Aston married to Floyd I. Grace on June 19, 1919 in the County of Bannock, State of Idaho

Viewed by V. S.

Amended July 2, 1965

United States
Department of Commerce
Bureau of the Census

Certificate Of Death

STATE OF IDAHO

State File No. 60691
Local Reg. No. 14
Reg. Dist. No. 19

1. PLACE OF DEATH:

- (a) County **Minidoka**
(b) City or town **Rupert**
(c) Street Address or R.F.D. No.
(d) Death Occured Inside?..... Outside?..... city or town
(e) Died in a Home... Hospital... Institution... Other place...
(f) Name Hosp. or Inst. Stayed..... days
(g) Lived in this county..... years months days

Note. For a person residing in THIS county LESS than 1 year, give FORMER residence under item 2.

2. Usual Residence of Deceased: (Always fill in these)

- (a) State **Idaho** (b) County **Minidoka**
(c) City or town **Rupert**
(d) Street Address or R.F.D. No.
(e) Deceased lived Inside?..... Outside?..... city or town
(f) Citizen of what country?
(g) How long had deceased lived in Idaho?..... years
(h) Former residence (city, state)

3. (a) FULL NAME**Stillborn Grace**

3. (b) If veteran, name war No.
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Child**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Date of Birth (Month, Day, Year) **March 1, 1928**

8. AGE	Years	Months	Days	If less than 1 day
				hrs min.

9. Exact Occupation **Stillborn** Did this work for yrs.
10. Industry or Business Date last worked
11. Birthplace **Rupert, Idaho**
(City or town) (State or foreign country)

12. Name **Floyd I. Grace**
13. Birthplace **Kentucky**
(City or town) (State or foreign country)
14. Maiden name **Mae Aston**
15. Birthplace **Idaho**
(City or town) (State or foreign country)

16. Informant's **Floyd I. Grace**
OWN Signature **Rupert, Idaho**
and Address

17. (a) (b) Date thereof
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place:

18. Funeral Director's **None**
OWN Signature
and Address

19. (a) **3-3-1928** (b) **E. H. Elmore**
(Date received and filed) (Registrar's signature)

MEDICAL CERTIFICATE OF DEATH

20. **DATE OF DEATH** **March 1** 28
(Month, Day, Year) 19.....
at..... o'clock M.

21. **I HEREBY CERTIFY**, That I attended deceased from
19....., to 19.....

I last saw h..... alive on 19.....; death is said to have occurred on the date and hour stated above.

Immediate Cause of Death:

Duration

Stillbirth

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

7½ Mo. Gestation

Where was disease contracted?.....

Name of operation Date.....

Major finding

Finding of autopsy

PHYSICIAN
Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to **EXTERNAL CAUSES**, also fill in the following: Accident?..... Suicide?..... Homicide?.....
Occurred..... 19..... City, county, state where violence occurred
Place of Violence: Home..... Farm..... Industry.....
Public Place..... While at work?.....
Means of injury

23. Attendant's **E. H. Elmore, M.D.**
OWN Signature
and Address **Rupert, Idaho** (M. D. or other) Date **3-3-** 19 **28**

(For additional space, use reverse side)

Informant, Funeral Director, Registrar and Medical Attendant, EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215). Address correspondence to State Bureau of Vital Statistics, Boise, Idaho.

DUTIES:

1. INFORMANT shall SIGN HIS OWN NAME, under item 16 to authenticate the facts stated under items 1 to 15, inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. The FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.
3. The REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including SIGNATURES IN BLACK ink under items 16, 18 and 23.

PENALTIES: Under the Idaho law, it is a misdemeanor to

- (a) Knowingly supply false information to any one connected with completing a death certificate;
- (b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
- (c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
- (d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated. For deaths occurring in a private home, "Home" should be checked. For deaths occurring on a highway, in a business house, on the street, at work, etc., "Other place" should be checked.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence. For those having a former IDAHO residence, additional care should be taken to state the correct COUNTY and the length of residence in IDAHO.

EXAMPLES

IMMEDIATE CAUSE OF DEATH:	DURATION	IMMEDIATE CAUSE OF DEATH:	DURATION
..... Cerebral hemorrhage .....	..... 1 day .....	..... Hypostatic pneumonia .....	..... 7 days
Due to..... Skull fracture .....	..... 1 day	Due to .....	.....
Due to..... Auto accident .....	..... 1 day .....	..... Cancer of stomach .....	..... 2 years
Other conditions..... Multiple fractures .....	..... 1 day	Due to .....	.....
(Include pregnancy within 3 months of death)		Other conditions..... Secondary anemia .....	..... 2 years
Where was disease first contracted? Public place.....		(Include pregnancy within 3 months of death)	
Name of operation..... Exp. Craniotomy	Date..... 11-12-45.....	Where was disease first contracted?..... Idaho	
Major finding..... Middle meningeal hemorrhage.....		Name of operation..... Gastroenterostomy.....	Date..... 11-12-45.....
Finding of autopsy..... Cerebral hemorrhage.....		Major finding..... Cancer of pylorus of stomach	
..... multiple skeletal fractures		Finding of autopsy..... Lobal pneumonia,	
		..... generalized carcinomatosis	
22. If death was due to EXTERNAL CAUSES, also fill in the following: Accident? ..yes... Suicide?	Homicide?.....	22. If death was due to EXTERNAL CAUSES, also fill in the following: Accident?..... Suicide?..... Homicide?.....	
Occurred..... 11-12..... 1945 City, county, state		Occurred..... 19..... City, county, state	
where violence occurred..... Boise, Ada, Idaho.....		where violence occurred.....	
Place of Violence: Home..... Farm..... Industry.....		Place of Violence: Home..... Farm..... Industry.....	
Public place ..yes... While at Work ..yes...		Public Place..... While at work?	
Means of injury..... auto-truck collision.....		Means of injury	

This body embalmed under direction of Lic. No. at on.....
ADDITIONAL REMARKS By Physician:

IDAHO DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

3-12-65

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of..... }
County of..... } ss.

Certificate No. 60691

Date Filed.....

The undersigned does solemnly swear that certain facts on the certificate of..... Death
for..... Stillborn Grace..... who died..... on Mar. 1, 1928
(Name on Original Certificate) (Was Born or Died) (Date of Event)
in..... Rupert, Idaho..... are erroneous or were omitted; and that, to the best of his knowledge, the
(Place of Event)
true facts are shown by..... prepared on....., are:
(Bible Record, Insurance Policy, Etc.) (Give Date)

FACTS TO BE CORRECTED
("Name," "Birth Date," "Cause of Death," Etc.)

FROM
(As on Original)

TO
(The Correct Facts)

Stillborn Grace
mother's name..... May Astle..... Mae Aston

Subscribed and sworn to before me this 8th day of
April, 1965

Signed Lallon R. Moncur
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

314 Catterell Dr. Boise, Idaho
(Street Address, City, State)

Notary Public, residing at.....
My commission expires.....
(Seal)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of..... }
County of..... } ss.

[This Affidavit **MUST** Also be Executed.
(See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 8th day of
April, 1965

Signed Frieda R. Moncur
(Signature of Any Credible Person)

314 Catterell Dr. Boise, Idaho
(Street Address, City, State)

Notary Public, residing at.....
My commission expires.....
(Seal)

Certificate of Membership in L.B.S. church gives maiden name of mother as Mae Aston, mother of Eva Mae Grace. James H. Gilbert, Bishop in L.B.S. Church accepted Jan. 24, 1926 in Kelly Ward, Idaho
Viewed by V.S.

Marriage License gives name as Mae Aston married to Floyd I. Grace on June 19, 1919 in the County of Bannock, Stat of Idaho.
Viewed by V. S.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

957-128-RECEIVED MAR 1 1928
PLACE OF BIRTH

STATE OF IDAHO

S

County of Payette.
City of Payette.

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

159560A

No. 1012 - 1st. Ave St. So.
957-228-038-343

Registration District No. 4 State File No. 1008

(If born in hospital or institution
give name.)

Prim. Registration District No. 1008 Local Registrar's No. 20

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin <u>Twins</u>	Triplet <u>and</u>	Number <u>1</u>	in order <u>of birth</u>	Legiti- mate? <u>Yes</u>	Date of birth <u>Feb. 28, 1928</u>
<u>Female</u>	(To be answered only in event of plural births)					(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? -----

Number of child of this mother, including present birth 2 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 2

FATHER
FULL NAME Bert Alexander Ingram

MOTHER
FULL MAIDEN NAME Nevada Tucke.

Residence (Usual place of abode) Payette, Idaho

Residence (Usual place of abode) Payette, Idaho

If nonresident, give place and State -----

If nonresident, give place and State -----

Color or race White Age at last Birthday 24
(Years)

Color or race White Age at last Birthday 17
(Years)

Birthplace Oregon
(City and State or Country)

Birthplace Nevada
(City and State or Country)

Occupation Farmer

Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } Stillborn
on the date above stated. { Stillborn } at 5.00 a. M.

(Signature) J. C. Woodward
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Payette, Idaho

Filed Feb. 28 19 28
Registrar. J. C. Woodward

PLACE OF BIRTH
 1911-12-15
 COUNTY OF
 STATE OF
 1911-12-15
 1911-12-15
 1911-12-15
 1911-12-15
 1911-12-15

[illegible]

1. **NAME** _____
 2. **DATE** _____
 3. **LOCATION** _____
 4. **TIME** _____
 5. **WEATHER** _____
 6. **WIND** _____
 7. **WAVE** _____
 8. **SEA** _____
 9. **SKY** _____
 10. **TEMP** _____
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[illegible]

1. Name of the person: Barbara L. Smith
 2. Address: 1000 1st St. N.E.
Washington, D.C.
 3. Date: Feb 10 1966
 4. Signature: [Signature]
 5. Title: President
 6. Organization: Barbara L. Smith
 7. Phone: 202-331-1234
 8. Fax: 202-331-1234
 9. E-mail: barbara@smith.com
 10. Other: None

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

957-228-238-343
PLACE OF BIRTH
County of. Payette
City of. Payette
No. 1012 Shirley Ave. S. St.
(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 159560B

Registration District No. 4 State File No. 1008
Prim. Registration District No. 1008 Local Registrar's No. 20-B

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth <u>2</u>	Legiti- mate? <u>Yes</u>	Date of birth <u>Feb 28</u> (Month) (Day) (Year) <u>1928</u>
----------------------------	---	-------	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 2
Born alive but now dead 0 Stillborn 2

FATHER	MOTHER
FULL NAME <u>Bert Alexander Ingram</u>	FULL MAIDEN NAME <u>Nevada Lucke</u>
Residence (Usual place of abode) <u>Payette Ida</u>	Residence (Usual place of abode) <u>Payette Ida</u>
If nonresident, give place and State	If nonresident, give place and State
Color or race <u>White</u> Age at last Birthday <u>24</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>17</u> (Years)
Birthplace <u>Oregon</u> (City and State or Country)	Birthplace <u>Nevada</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 5:00 M.
on the date above stated.

(Signature) J. C. Woodward

(Physician or midwife)

Address Payette Idaho

Filed Feb 28 1928 J. C. Woodward

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DEPARTMENT OF THE ARMY
BUREAU OF MILITARY INTELLIGENCE
OFFICE OF THE CHIEF OF BUREAU

PLACE OF ORIGIN

Country of
City of

No.

It is to be noted in a report of intelligence
that...

FULL NAME OF CHINESE

(If known) Name and rank of person...

CHINESE

What cryptographic was used to prevent disclosure of contents?

Indicate in which of the various methods of communication...

STATION

PLANT
MACHINE
TYPE

Indicate (Type of machine)

It is recommended that...

Indicate (Type of machine)

Indicate (Type of machine)

Indicate (Type of machine)

(Signature)

Indicate (Type of machine)

Indicate (Type of machine)

Indicate (Type of machine)

Indicate (Type of machine)

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

619-2055004-795
PLACE OF BIRTH RECEIVED MAR 6 1928
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
S
CERTIFICATE OF BIRTH
159581

County of Idaho
City of Idaho Falls
No. _____ St. _____
(If born in hospital or institution give name.)
Registration District No. 77 State File No. _____
Prim. Registration District No. 2176 Local Registrar's No. 74

FULL NAME OF CHILD _____
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>+</u>	Date of birth <u>2/5</u> (Month) (Day) (Year) <u>1928</u>
-----------------------	---	---	---------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Atropine 10%

Number of child of this mother, including present birth 7th (a) Born alive and now living 6
Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Norman Ward</u> Residence (Usual place of abode) <u>Idaho Falls, Id.</u> If nonresident, give place and State _____ Color or race <u>W</u> Age at last Birthday <u>44</u> (Years) Birthplace <u>Idaho</u> (City and State or Country) Occupation <u>Farmer</u>	MOTHER FULL MAIDEN NAME <u>Luella Knew</u> Residence (Usual place of abode) <u>Id.</u> If nonresident, give place and State _____ Color or race <u>W</u> Age at last Birthday <u>35</u> (Years) Birthplace <u>Idaho</u> (City and State or Country) Occupation <u>Homemaker</u>
--	---

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive ✓ Stillborn ✓ at 8:15 P. M.
on the date above stated.

(Signature) S. T. Peterson, M.D.
(Physician or midwife)
Address Idaho Falls, Idaho
Filed 29 - 1928 Martha Marker
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF CALIFORNIA
 COUNTY OF ...
 DEPARTMENT OF ...

Register also known as No. ...
 Person Registered District No. ...

FULL NAME OF CHILD

Sex of Child	Age of Child	Date of Birth
...

Is the child a child of the person registered? () Yes () No
 If yes, state the name of the person registered: ...

Is the child a child of the person registered? () Yes () No	Is the child a child of the person registered? () Yes () No
...	...

Is the child a child of the person registered? () Yes () No

I hereby certify that I attended the birth of this child who was ...
 on the ... day of ...

(Signature) ...
 There was no attending physician ...

FORM V. S. No. 5-26-11-1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **60739**
Registered No. **5**

1. PLACE OF DEATH

County of IdahoRegistration District No. 77City of Leti, IdahoPrimary Registration District No. 2176
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

M

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

1928
(Year)

7. AGE

Still born
Yrs. Mos. ds.

IF LESS than 1 day
how many..... hrs.
or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Norman Hard

11. BIRTHPLACE OF FATHER

(State or Country)

Leti, Idaho

12. MAIDEN NAME OF MOTHER

Luella Green

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Norman Hard
Leti, Idaho

15.

Filed 3-29-1928Martin Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1928
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

.....19.....

to

.....19.....

that I last saw him..... alive on.....19.....

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Died presumably 2/3/28Two days before birth

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)Accidental hemorrhage, i.e., placenta separation

(Duration)

Yrs.

mos.

ds.

(Signed)

L.F.F. Redner

M. D.

2/6 1928

(Address)

Leti, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days. In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leti, Idaho3-6-1928

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

436-208-014-141 PLACE OF BIRTH

STATE OF IDAHO

Form No. 11-C-10m-8-7-11

City of _____

Registration District No. _____

File No. 159652

No. _____ St. _____

Primary Registration District No. 2007

Registered No. 22

Hospital _____

FULL NAME OF CHILD McFadden

Sex of Child <input checked="" type="checkbox"/> Male	Twin, Triplet or other? <input checked="" type="checkbox"/>	and Number in order of birth <input checked="" type="checkbox"/>	Legitimate? <input checked="" type="checkbox"/> yes	Date of birth 2/8/28 (Month) (Day) (Year)
FULL NAME FATHER Jesse McFadden		FULL MAIDEN NAME MOTHER Carol Adams		
RESIDENCE Weldon Idaho		RESIDENCE Weldon Idaho		
COLOR W	AGE AT LAST BIRTHDAY 39 (Years)	COLOR W	AGE AT LAST BIRTHDAY 31 (Years)	
BIRTHPLACE Weldon Idaho		BIRTHPLACE Oregon		
OCCUPATION Farmer		OCCUPATION Housewife		

Number of child of this mother, including present birth 5 Number of children, of this mother, now living, including present birth 4

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at 8:15 a.m. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. J. Sarazen M.D.
(Physician or Midwife)

Given names added from a supplemental report

Address _____
Filed 3/10/28 _____
Registrar _____

Reported next page

12

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 9 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 60596

PLACE OF DEATH

County of Canyon
City of _____

Registration District No. 3Primary Registration District No. 2007Local Registrar's No. 8(No. _____)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)2. FULL NAME Jessie M. Fadden(a) Residence. No. _____ St. Wilder Idaho

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) Feb 8th 1928

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country)

10 NAME OF FATHER

Jesse M. Fadden11 BIRTHPLACE OF FATHER (city or town)
(State or country)Wilder Idaho

12 MAIDEN NAME OF MOTHER

Coil Adams13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Wallona, Or.

14

Informant
(Address)Jessie M. Fadden
Wilder Idaho

15

Filed 9

1928

Lulu Caldwell
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb

(Month)

8th

(Day)

1928

(Year)

17

I HEREBY CERTIFY, That I attended deceased from
Feb 8, 1928, to _____, 19____.that I last saw him alive on Still Born, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Asphyxia. Pressure on
cord.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?at place of deathDid an operation precede death? No Date of _____Was there an autopsy? NoWhat test confirmed diagnosis? Chemical

(Signed)

J. J. Caravan

M. D.

(Address)

Myra Ave

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Carma CemeteryFeb 8 1928

20. Undertaker

Address

C. V. PeckhamCaldwell

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Fiferman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

162-215-00-768
PLACE OF BIRTH
County of Idaho
City of Meridian
No. _____ St. _____
Registration District No. _____ State File No. _____
(If born in hospital or institution give name.)
Prim. Registration District No. 2003 Local Registrar's No. 5

FULL NAME OF CHILD Baby Moser
If stillborn, substitute the word "Stillbirth" for name of child

Sex of Child <u>Female</u>	Twin Triplet or other? <u>No</u> (To be answered only in event of plural births)	and { Number in order of birth <u>1</u> }	Legitimate? <u>yes</u>	Date of birth <u>2</u> / <u>15</u> / <u>1928</u> (Month) (Day) (Year)
----------------------------	---	---	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 15 (a) Born alive and now living 9

Born alive but now dead _____ Stillborn six

FATHER	MOTHER
FULL NAME <u>Ludwig P. Moser</u>	FULL MAIDEN NAME <u>Christina Pohley</u>
Residence (Usual place of abode) <u>Meridian Idaho</u>	Residence (Usual place of abode) <u>Meridian Idaho</u>
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>white</u> Age at last Birthday <u>40</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>39</u> (Years)
Birthplace <u>Russia</u> (City and State or Country)	Birthplace <u>Russia</u> (City and State or Country)
Occupation <u>laborer</u>	Occupation <u>at home</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 10 A. M.
on the date above stated.

(Signature) Stebornoff
Physician
(Physician or midwife)

Address Meridian Idaho

Filed 9/8 1928 TH

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

GREENING THE HANDBOOK A P. 10 SHEET NEW ENGLAND MEDICAL JOURNAL
 TO BE KEPT IN THE HANDBOOK A P. 10 SHEET NEW ENGLAND MEDICAL JOURNAL
 TO BE KEPT IN THE HANDBOOK A P. 10 SHEET NEW ENGLAND MEDICAL JOURNAL

DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

Full Name of Child: John William
 Date of Birth: 1918
 Place of Birth: John William
 Sex: Male
 Color: White
 Height: 5 ft 0 in
 Weight: 15 lb
 Head: 13 in
 Chest: 18 in
 Arms: 18 in
 Legs: 18 in
 Feet: 10 in
 Fingers: 10 in
 Toes: 10 in
 Birth: 1918
 Place: John William
 Sex: Male
 Color: White
 Height: 5 ft 0 in
 Weight: 15 lb
 Head: 13 in
 Chest: 18 in
 Arms: 18 in
 Legs: 18 in
 Feet: 10 in
 Fingers: 10 in
 Toes: 10 in

FATHER: John William
 MOTHER: John William
 Full Name: John William
 Date of Birth: 1918
 Place of Birth: John William
 Sex: Male
 Color: White
 Height: 5 ft 0 in
 Weight: 15 lb
 Head: 13 in
 Chest: 18 in
 Arms: 18 in
 Legs: 18 in
 Feet: 10 in
 Fingers: 10 in
 Toes: 10 in

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was born on the 1918 day of John William at John William
 (Signature)
 Address: John William
 Date: 1918

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 17 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **60821**

PLACE OF DEATH

County of Ada
City of Meridian

CERTIFICATE OF DEATH

Registration District No. 11Primary Registration District No. 2003Local Registrar's No. 9

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still Born

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Meridian Id.
(State or country)10 NAME OF FATHER J. P. Fraser11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)12 MAIDEN NAME OF MOTHER Christina Gold13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)14 Informant L. J. Fraser
(Address) Meridian Id.15 Filed Feb 16, 1928 J. H. Fraser
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 15 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1928, to Feb 15, 1928.

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Still Birth

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY injury
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) _____, M. D.

19 _____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Meridian Cemetery Feb 16 1928

20. Undertaker

Address

W. J. Fraser Meridian

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

tem for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

253209-2 RECEIVED APR 7 1928
PLACE OF BIRTH
County of Bingham
City of Blackfoot
No. 106413 St. Registration District No. 121 State File No. 159869
Hospital _____ Primary Registration District No. 2194 Local Registrar's No. 101
FULL NAME OF CHILD George Anna Bethel
(Certificate of no value without full name of child)

Sex of Child Girl Twin Triplet or other? _____ and { Number in order of birth _____ Legitimacy yes Date of birth March 9 1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 32
FULL NAME FATHER George W. Bethel FULL MAIDEN NAME MOTHER Cora Mackie
RESIDENCE Blackfoot, Idaho #3 RESIDENCE Blackfoot, Idaho
COLOR white AGE AT LAST BIRTHDAY 34 COLOR white AGE AT LAST BIRTHDAY 30
(Years) (Years)
BIRTHPLACE Blackfoot, Idaho BIRTHPLACE Blackfoot, Idaho
OCCUPATION Farmer OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at Blackfoot M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) F W Mitchell

(Physician or midwife)

Address Blackfoot, Idaho

Filed April 2 1928

Registrar.

Registrar.

RECEIVED APR 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **60856**Local Registrar's No. **23**

PLACE OF DEATH

County of Bingham
City of Blackfoot

CERTIFICATE OF DEATH

Registration District No. 121
Primary Registration District No. 2194
(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Arnold Butthell

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____6 DATE OF BIRTH (month, day and year) 3/9/287 AGE Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Blackfoot, Idaho
(State or country)10 NAME OF FATHER George M. Butthell11 BIRTHPLACE OF FATHER (city or town) Blackfoot, Idaho
(State or country)12 MAIDEN NAME OF MOTHER Cara Mudd13 BIRTHPLACE OF MOTHER (city or town) Blackfoot, Idaho
(State or country)14 Informant George H. Butthell
(Address) W. A. B. Co.15 Filed Mar 27 1928 W. A. B. Co. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 9 1928
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from March 9, 1928, to March 9, 1928, that I last saw her alive on March 9, 1928, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:Still born, died in utero(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Over work of mother
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted _____
If not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) H. A. Mutchell M. D.
3/10, 1928 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Home City Cemetery Date of Burial 3-10 192820. Undertaker Exp. Frank Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

492-120-006 RECEIVED APR 7 1928
PLACE OF BIRTH *Idaho*
COUNTY OF *Blaine*
CITY OF *Blackfoot*
No. *Phonics* St. Registration District No. *121* State File No. *159872*
Hospital Primary Registration District No. *2194* Local Registrar's No. *104*
FULL NAME OF CHILD *Imurakichi Miel*
(Certificate of no value without full name of child)

Sex of Child <i>Male</i>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate?	Date of birth <i>March 20</i> 192 <i>8</i> (Month) (Day) (Year)
-----------------------------	---	--------------------------------------	------------------	---

What bactericidal solution was used in eyes? *yes*

Number of child of this mother, including present birth *3* Number of child of this mother now living, including present birth *2*

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<i>Schimatsu Miel</i>	<i>Blackfoot, Idaho #2</i>	<i>Yokono, Fuchou</i>	<i>Blackfoot, Idaho #2</i>
COLOR <i>Jap</i>	AGE AT LAST BIRTHDAY <i>52</i> (Years)	COLOR <i>Jap</i>	AGE AT LAST BIRTHDAY <i>38</i> (Years)
BIRTHPLACE <i>Japan</i>		BIRTHPLACE <i>Japan</i>	
OCCUPATION <i>Farmer</i>		OCCUPATION <i>Housewife</i>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *Stillborn* at *5:00* A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) *F. W. Mitchell*

(Physician or midwife)

Address *Blackfoot, Idaho*

Filed *April 2* 192*8*

Registrar.

Registrar.

RECEIVED APR 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 60858

Local Registrar's No. 36

PLACE OF DEATH

County of Bingham
City of Blackfoot

CERTIFICATE OF DEATH

Registration District No. 121Primary Registration District No. 2194(No. _____)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)2. FULL NAME Schmatosa Miel

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Wp 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____6 DATE OF BIRTH (month, day and year) March 20 19287 AGE Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Blackfoot, Idaho
(State or country)10 NAME OF FATHER Schmatosa Miel11 BIRTHPLACE OF FATHER (city or town) Japan
(State or country)12 MAIDEN NAME OF MOTHER Yakoma Fuchsei13 BIRTHPLACE OF MOTHER (city or town) Japan
(State or country)14 Informant C. Miel(Address) Blackfoot, Idaho15 File March 21, 1928 McClister E. F. Walker
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 20 1928
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from March 20, 1928, to March 20, 1928,
that I last saw him alive on March 20, 1928,
and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Still born.

(duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY Over work of mother
(Secondary)

(duration) _____ yrs. _____ mos. _____ da.

18 Where was disease contracted _____
If not at place of death?Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) H. W. Mitchell M. D.
3-20, 1928 (Address) Blackfoot, Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.19 Place of Burial, Cremation, or Removal Paradise IdahoDate of Burial 3-21 192820. Undertaker E. J. PankAddress Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection, with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

993-122-007-231
PLACE OF BIRTH

RECEIVED APR 16 1928
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Blaine

City of Larey

No. _____ St. _____

Registration District No. 57

State File No. 159895

Hospital _____

Primary Registration District No. 2025

Local Registrar's No. 9

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child

Male

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

3-22-1928

(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 4

Number of child of this mother now living, including present birth 2

FULL
NAME

FATHER

William R. Richards

RESIDENCE

Larey, Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

34

(Years)

BIRTHPLACE

Ogden Utah

OCCUPATION

Farmer

FULL
NAME

MOTHER

Vernal Louise Stanford

RESIDENCE

Larey, Idaho

COLOR

white

AGE AT LAST
BIRTHDAY

32

(Years)

BIRTHPLACE

Salt Lake City, Utah

OCCUPATION

House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 10:15 a. m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 1928

Registrar.

(Signature)

E. W. Fox

Physician

(Physician or midwife)

Address

Shoshone, Idaho

Filed

4-1-1928

Robert H. Wright

Registrar.

Registration No. _____ State of _____
Primary Registration District No. _____ and Local District No. _____

(Certificate of no value without full record of child)

(TheY) (TEC) (HARRIS)

There are four new stations established in 1977

Number of child of this mother was listed incorrectly as 1

PHANTOM

NAME
ADDRESS
CITY

● 2010年10月1日起实施

AGE AT LAST
BIRTHDAY

NOTES

1941-1947 年刊

NOTA 94290

AGENTA

東國英學

TRAIL TA
YACHTING

2024

References

MOBILE 320

(b)(7)(D)

(S) [REDACTED]

There were no other persons present at the time of the shooting.

100

FORM V. S. No. 5-25 M. 1-16-18

1. PLACE OF DEATH **RECEIVED APR 4**
 Registration District No. 57
 County of Blaine
 Primary Registration District No. 2075
 City of Carey (No. _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 60867
 Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. Single
 (Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH

3- 22 1928
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many 2 hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Carey, Idaho10. NAME OF FATHER Wm. B. Richards

11. BIRTHPLACE OF FATHER

(State or Country) Ogden, Utah12. MAIDEN NAME OF MOTHER Vernal Louise Stanford

13. BIRTHPLACE OF MOTHER

(State or Country) Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Richards(Address) Carey, Idaho

15.

Filed 4 - 1 19128

R. H. Wright
 Local Registrar

16. DATE OF DEATH 3- 22 1928
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191,
 that I last saw h. alive on 191
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born. 9 mos fetus
For general malformation
Spina Bifida
 (Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) E. W. Foster M. D.
3/22-1928 (Address) Shoshone, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carey, Idaho3/24 19128

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

29-1-13-008-319
PLACE OF RECEIVED APR 7 1928
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Bonner
CITY OF Landpoint
No. Carnell Hospital
Registration District No. 78 State File No. 159915
(If born in hospital or institution give name.)
Prim. Registration District No. 2155 Local Registrar's No. _____
FULL NAME OF CHILD Stillborn Brackett
(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child Male Twin Triplet or other? and Number in order of birth Legitimate? Yes Date of birth March 13 1928
(To be answered only in event of plural births) (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? none
Number of child of this mother, including present birth 7 (a) Born alive and now living 3
Born alive but now dead 4 Stillborn 3
FATHER FULL NAME Peter H Brackett MOTHER FULL MAIDEN NAME Mattie Larson
Residence (Usual place of abode) Samuel, Ida Residence (Usual place of abode) Samuel, Ida
If nonresident, give place and State _____ If nonresident, give place and State _____
Color or race White Age at last Birthday 33 Color or race White Age at last Birthday 34
Birthplace Yakima Wash. (City and State or Country) Birthplace Illinois (City and State or Country)
Occupation Rancher Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12:15 P. M.
on the date above stated. (Signature) W. G. Wendle
W. G.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Landpoint, Ida
Filed April 5 1928 Viola Allen
Deputy Registrar.

0800Z JUL 69
FM JCRC
TO DIA
INFO JCS
SUBJ: RECENT ACTIVITY OF THE
REPUBLICAN PARTY IN THE
UNITED STATES

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO

RECEIVED APR 7 1928
PLACE OF DEATH

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 30869

County of Bonner
City of Sandpoint

Registration District No. 76
Primary Registration District No. 2155-

Local Registrar's No.

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)
2. FULL NAME Stillborn Brackett
(a) Residence. No. Samuels, Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) March 13, 1928
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Stillborn
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint (State or country) Idaho
10. NAME OF FATHER Peter W. Brackett
11. BIRTHPLACE OF FATHER (city or town) Yakima (State or Country) Wash.
12. MAIDEN NAME OF MOTHER Mattie Larson
13. BIRTHPLACE OF MOTHER (city or town) Illinois (State or Country)

14. Informant Peter D. Brackett
(Address) Samuels, Idaho

15. Filed March 13, 1928 Viola Allen
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 13, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:
maternal fall -
traumatism
7 months gestation
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY habitual abortion
(Secondary)
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____

What test confirmed diagnosis?
(Signed) Floyd G. Wendle, M. D.
March 13, 1928 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial
Crematory disposal at March 13, 1928

20. Undertaker Address
Parnell Hospital Sandpoint, Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

415-102-509-619

PLACE OF BIRTH

RECEIVED

APR 7 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Bonner

City of Sandpoint

No. St.

Sandpoint Hosp.

(If born in hospital or institution
give name.)

Registration District No. 76

State File No. 159917

Prim. Registration District No. 2155

Local Registrar's No.

FULL NAME OF CHILD

"Stillbirth" Davis.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of

Child

Male

Twin
Triplet
or other?

}

and

}

Number
in order
of birth

Legiti-
mate?

yes

Date of

birth

Feb. 2.

1928

(Month)

(Day)

(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 8

(a) Born alive and now living

Born alive but now dead

Stillborn

Yes

FATHER

FULL
NAME

Morton Dillard Davis

Residence (Usual place of abode) Sagle

If nonresident, give place and State

Color or race white Age at last Birthday 39

(Years)

Birthplace Prarie City Oregon.

(City and State or Country)

Occupation

Rancher

MOTHER

FULL
MAIDEN
NAME

Effie Elizabeth Ward

Residence (Usual place of abode) Sagle

If nonresident, give place and State

Color or race white Age at last Birthday 35

(Years)

Birthplace Decature, Tenn.

(City and State or Country)

Occupation

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9:20 P.M.
on the date above stated.

(Signature)

C. P. Stackhouse

Physician

(Physician or midwife)

Address Sandpoint, Idaho.

Filed April 5 1928

Viola Allers
Deputy
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

100-443887-100

1



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 60537

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Infant Davis

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (Write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 2, 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min. Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sandpoint Idaho

10. NAME OF FATHER Dillard Davis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Eve Ward

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Dillard Davis
(Address) Algoma, Idaho

15. Filed Feb 3 19 28 Viol. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 2, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at
birth 7/2/28 19, to, 19,
that I last saw h. alive on, 19,
and that death occurred, on the date stated above, at, m.

The CAUSE OF DEATH* was as follows:

Stillborn - Shoulder presentation
Converted into breech - Delayed
head delivery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. P. Stuehse M. D.

2-3- 19 28 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal Highland Cemetery Date of Burial Feb. 3, 1928

20. Undertaker H. H. Moon Address Sandpoint Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

295-129-01X-265
PLACE RECEIVED APR 10 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Canyon
City of _____
No. _____ St. _____

CERTIFICATE OF BIRTH

S
159969

Registration District No. 3 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 2 Local Registrar's No. 3

FULL NAME OF CHILD Infant Kreizenbeck

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>m</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>march 29</u> 192 <u>8</u> (Month) (Day) (Year)
-----------------------	---	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>Carl Kreizenbeck</u>	MOTHER FULL MAIDEN NAME <u>Elise Boehmgen</u>
---	--

Residence (Usual place of abode) _____

If nonresident, give place and State _____

Color or race W Age at last Birthday 38 (Years)

Birthplace net (City and State or Country)

Occupation farmer

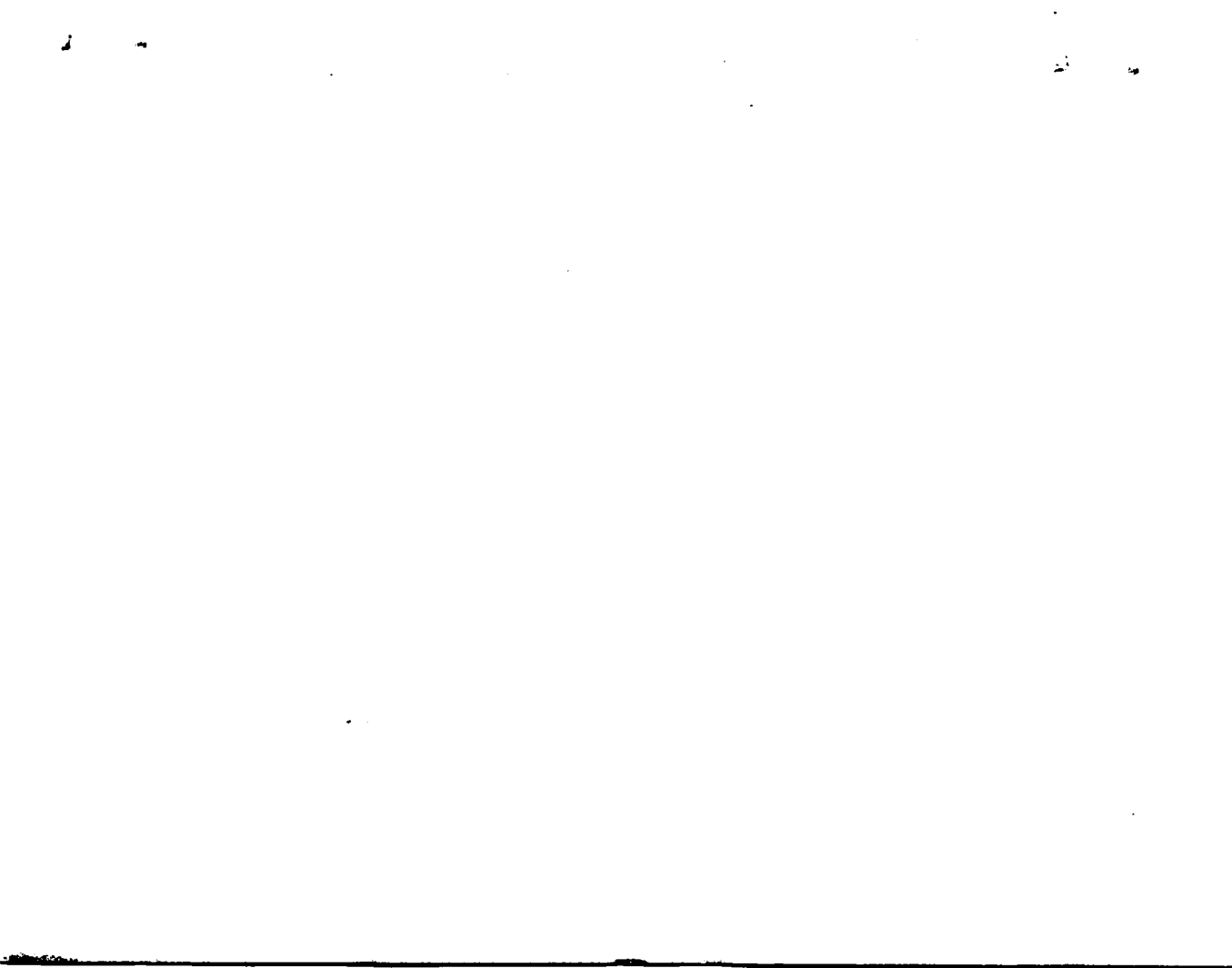
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Not stillborn} at 6:30 P M.
on the date above stated.

(Signature) W. E. Waldrop
m l d
(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address Parnua
Filed 4/10 1928 Lulu Waldrop
Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 17 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 60892

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 3
Primary Registration District No. 2007
(No. _____)

Local Registrar's No. 9

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Kreizenbeck

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) _____

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Stillborn baby

6 DATE OF BIRTH (month, day and year) March 29, 1928

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Parma Idaho
(State or country)10 NAME OF FATHER Carl Kreizenbeck11 BIRTHPLACE OF FATHER (city or town) Petersburg Neb.
(State or country)12 MAIDEN NAME OF MOTHER Elise Boehringer13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)14 Informant Carl Kreizenbeck, Jr.
(Address) Parma Idaho15 Filled _____, 19 _____ Julius Waldorf
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 29 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Stillborn, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Fetus & development of bones of head
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____Did an operation precede death? no Date of _____Was there an autopsy? noWhat test confirmed diagnosis? Examination(Signed) Dr. J. Waldorf, M. D.March 30 1928 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal _____ Date of Burial _____ 19____

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Cassia
City of Burley
No. 249-3071016-753 St.

Registration District No. 117

State File No.

160013

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

(If born in hospital or institution
give name.)

Prim. Registration District No. 2196 Local Registrar's No. 79

FULL NAME OF CHILD

Stillbirth ✓

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

Girl

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

Jan 7
(Month) (Day)

1938
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Ag. 13

Number of child of this mother, including present birth

8

(a) Born alive and now living

6

Born alive but now dead

Stillborn

FULL
NAME

FATHER
Thomas H. Smith

FULL
MAIDEN
NAME

MOTHER
Lottie Peck

Residence (Usual place of abode)

Burley, Ida.

Residence (Usual place of abode)

Burley, Ida.

If nonresident, give place and State

If nonresident, give place and State

Color or race

White Age at last Birthday 46
(Years)

Color or race

White Age at last Birthday 42
(Years)

Birthplace

Huntsville, Ala.
(City and State or Country)

Birthplace

Richmond, Va.
(City and State or Country)

Occupation

Farmer

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.

Born alive
Stillborn

at 9:00 A M.

(Signature)

D. H. Cooper M.D.

Physician and Surgeon
(Physician or midwife)

Address

Burley, Idaho

Filed

Mar 20 1938

217 H. E. ...

Registrar.

mrs. Brew

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

100

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED APR 9 1928

STATE OF IDAHO

County of Clearwater,
City of Weippe, Idaho.

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

No. 245218108544 St.

Registration District No. 90 State File No. 160024

(If born in hospital or institution
give name.)

Prim. Registration District No. 2168 Local Registrar's No. 35

FULL NAME OF CHILD Unnamed.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twins Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate ma? <u>No</u>	Date of birth <u>Feb. 18th.</u> 19 <u>28.</u>
					(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None.

Number of child of this mother, including present birth One (a) Born alive and now living None.

Born alive but now dead None Stillborn One.

FATHER
FULL NAME Forrest G. Sund.

MOTHER
FULL MAIDEN NAME Rhoda Edmondson.

Residence (Usual place of abode) Weippe, Idaho.

Residence (Usual place of abode) Weippe, Idaho.

If nonresident, give place and State

If nonresident, give place and State

Color or race White. Age at last Birthday 19. (Years)

Color or race White Age at last Birthday 19 (Years)

Birthplace Canada.
(City and State or Country)

Birthplace Cleveland, Ohio.
(City and State or Country)

Occupation Laborer.

Occupation House-work.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that ~~I attended~~ the birth of this child, who was Stillborn at 6:30 P. M. on the date above stated.

(Signature) J. M. Fairly

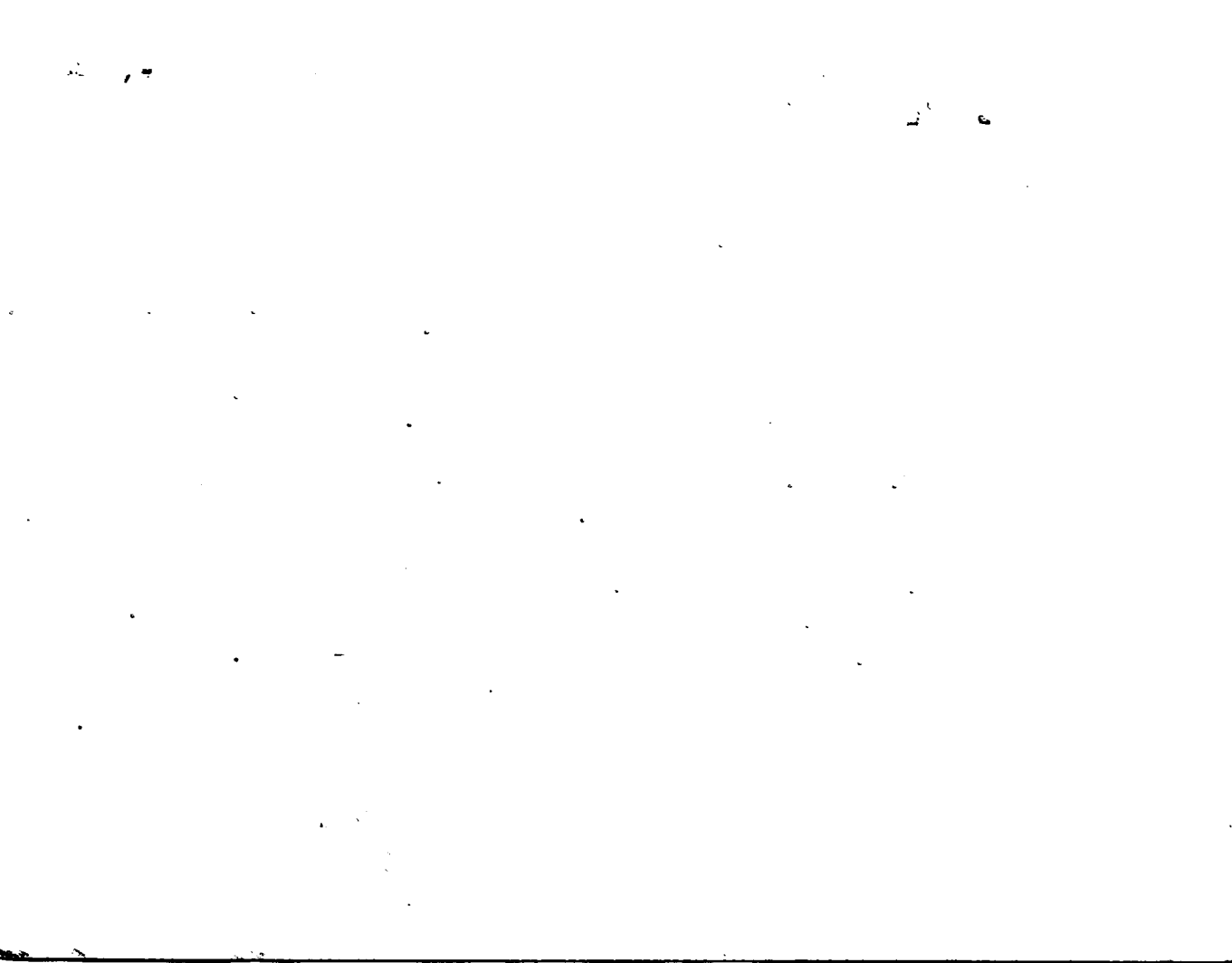
(Physician or midwife)

Address Bozino, Idaho

Filed April 6th. 28 J. M. Fairly

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. **RECEIVED APR 9 1928** CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. **90**
County of **Clearwater,** Primary Registration District No. **2168**
City of **Weippe, Idaho.** (No. _____, St.)

File No. **30908**

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Unnamed.**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female. White Single (Write the word.)

6. DATE OF BIRTH

February 18th. 1928.
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None, Stillborn.
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Weippe, Idaho.**

10. NAME OF FATHER

Forrest G Sund.

11. BIRTHPLACE OF FATHER

(State or Country) **Canada.**

12. MAIDEN NAME OF MOTHER

Rhoda Edmondson.

13. BIRTHPLACE OF MOTHER

(State or Country) **Cleveland, Ohio.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Rhoda Edmondson.**

(Address) **Weippe, Idaho.**

15.

Filed **April 6th. 1928**

J. M. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February 18th. 19**28**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to **191**,
that I last saw him alive on **191**,
and that death occurred on the date stated above, at **6:30 PM**.

The CAUSE OF DEATH* was as follows:

*Stricken with Choke and known
no physician in attendance*
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

4/6/28

(Address)

M. G. Smith M. D.
Dr. J. M. Smith

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Weippe, Idaho

DATE OF BURIAL

Feb. 18, 1928

20. UNDERTAKER

W. A. Shaw

ADDRESS

Galicia, Mo.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Clearwater
City of Grangemont

No. 415-2181018-113 St. 113

(If born in hospital or institution
give name.)

Registration District No. State File No. 160025

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>X</u>	Date of birth <u>Mar 18</u> 19 <u>28</u> (Month) (Day) (Year)
----------------------------	---	---	---------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 7 (a) Born alive and now living

Born alive but now dead _____ Stillborn Stillbirth

FATHER
FULL NAME Warren Orran Danner

Residence (Usual place of abode) Grangemont

If nonresident, give place and State Idaho

Color or race White Age at last Birthday 34 (Years)

Birthplace St Joseph Mo.
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Ethel Jane Mackland

Residence (Usual place of abode) Grangemont

If nonresident, give place and State Idaho

Color or race White Age at last Birthday 28 (Years)

Birthplace Seattle Wash.
(City and State or Country)

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn } at 8 A. M.
on the date above stated.

(Signature) Warren Orran Danner

Father

(Physician or midwife)

Address Grangemont Ida

Filed APR 7 1928 19 David Bunell

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

12

.....

Reference to [redacted] (Sect. 10)

51211 to 51212 for "S. 11111" now add "S. 11111" (1)



4-10-1964

HALL


1941

11/11/11

197

1990

... ..



100

15 OCT 1954

shows other evidence of the latter birth. Child is one that reelin' prescribes not etc, should make its nature. A stillborn or maimed, with the latter, hopelessly, *Where there was no attending physician

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS		DO NOT WRITE IN THIS SPACE State File No. 60903	
CERTIFICATE OF DEATH PLACE OF DEATH County of <u>Clearwater</u> City of <u>Granger</u> <u>Ida</u> Registration District No. _____ Primary Registration District No. _____ (No. _____) (If death occurred in a hospital or institution, give its name instead of street and number.)		Local Registrar's No. _____	
2. FULL NAME <u>Still born "Danner"</u>			
(a) Residence. No. _____ St. _____ (Usual place of abode) Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.			
PERSONAL AND STATISTICAL PARTICULARS			
3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word)	
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of			
6. DATE OF BIRTH (month, day and year) <u>Mar. 18-19 28</u>			
7. AGE	Years	Months	Days
			If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer			
9. BIRTHPLACE (city or town) <u>St. Joseph Mo.</u> (State or country)			
10. NAME OF FATHER <u>Warren Orren Danner</u>			
11. BIRTHPLACE OF FATHER (city or town) <u>St. Joseph Mo.</u> (State or Country) <u>Seattle Wash.</u>			
12. MAIDEN NAME OF MOTHER <u>Ethel Jane Mackland</u>			
13. BIRTHPLACE OF MOTHER (city or town) <u>Seattle Wash.</u> (State or Country)			
14. Informant _____ (Address)			
15. Filed <u>APR 7 1928</u> <u>David Burrell</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16. DATE OF DEATH <u>March 18 1928</u> (Month) (Day) (Year)			
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____ that I last saw h. _____ alive on _____, 19____ and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Stillbirth</u> _____ (duration) _____ yrs. _____ mos. _____ ds.			
CONTRIBUTORY (Secondary) _____ _____ (duration) _____ yrs. _____ mos. _____ ds.			
18. Where was disease contracted if not at place of death? Did an operation precede death? _____ Date of _____ Was there an autopsy? _____ What test confirmed diagnosis? (Signed) <u>Warren Orren Danner, M.D.</u> <u>no person attending</u> _____ 19____ (Address)			
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
19. Place of Burial, Cremation, or Removal		Date of Burial 19____	
20. Undertaker		Address	

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

769-124-221-753
PLACE OF BIRTH

County of Franklin
City of Preston
No. Route 1 St.

RECEIVED APR 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S-

Registration District No. 27 State File No. 160043
Prim. Registration District No. 2119 Local Registrar's No. 64

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Mar. 24, 1928</u>	<u>19</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 11 (a) Born alive and now living 10
Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME Albert E. Porter
Residence (Usual place of abode) Preston, Idaho. R #1
If nonresident, give place and State _____
Color or race White Age at last Birthday 42
Birthplace Idaho (Years)
Occupation Farming (City and State or Country)

MOTHER
FULL MAIDEN NAME Mary C. Peterson
Residence (Usual place of abode) Preston, Idaho. R #1
If nonresident, give place and State _____
Color or race White Age at last Birthday 41
Birthplace Idaho (Years)
Occupation Housewife (City and State or Country)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at _____ M.
on the date above stated.

(Signature) [Signature]
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Preston, Idaho
Filed Apr. 2, 1928 [Signature]
Registrar.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 2112
Local No. 1212
It is hereby certified that on the 12th day of March 1912, at the City of Boise, Idaho, a child was born to the wife of John Doe, of the County of Ada, Idaho.

Full Name of Child: John Doe
Sex of Child: Male
Date of Birth: March 12, 1912
Place of Birth: City of Boise, Idaho
Legitimacy: Legitimate
To be answered only in case of blood transfusion

What prophylactic was used to prevent Opium Intoxication?
Number of child of this mother, including present birth:
Given after birth: Yes

Parents: John Doe, Mary Doe
Residence (Usual place of abode):
If non-resident, give place and State:
Color of hair: Brown
Color of eyes: Blue
Birthplace: Idaho
(Give name of County)

Education: High School
Occupation: Clerk
Date of birth: March 12, 1912
Place of birth: City of Boise, Idaho
Legitimacy: Legitimate
To be answered only in case of blood transfusion

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I, _____, Physician or Midwife, do hereby certify that the above named child was born to the wife of John Doe, of the County of Ada, Idaho, on the 12th day of March 1912, at the City of Boise, Idaho.

Signature of Physician or Midwife: _____
Address: _____
City: _____
State: _____

*Where there was no attending physician or midwife, then the father, householder, or neighbor, should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

RECEIVED APR 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 60911

PLACE OF DEATH

Franklin

CERTIFICATE OF DEATH

County of Franklin

City of Preston, R.# 1

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No. 20

(If death occurred in a hospital or institution, give its name instead of street and number.)

Stillborn

2. FULL NAME

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced, (write the word)

Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

Mar. 24, 1928

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

Preston, Idaho. R.# 1

10. NAME OF FATHER Albert E. Porter

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER Mary C. Peterson

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Idaho

14. Informant Albert E. Porter

(Address) Preston, Idaho. R.# 1

15. Filed

Apr. 3, 1928

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 24

1928

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Accidental separation
of placenta due to hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Mar. 25, 1928

Preston

(Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal
Preston, Idaho

Date of Burial

19

20. Undertaker

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OR RECEIVED APR 2 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of FremontCity of AshtonNo. 313-128-022-769 St.Registration District No. 10State File No. 160084

Hospital

Primary Registration District No. 6

Local Registrar's No.

FULL NAME OF CHILD

Still born - Lacy

(Certificate of no value without full name of child)

Sex of Child maleTwin
Triplet
or other?} and { Number
in order
of birth
(To be answered only in event of plural births)Legiti-
mate? yesDate of birth 2-28-1928
(Month) (Day) (Year)What bactericidal solution was used in eyes? noneNumber of child of this mother, including present birth 1Number of child of this mother now living, including present birth 0FULL
NAME

FATHER

Gas. V. Lacy

RESIDENCE

Ashton, Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

26
(Years)

BIRTHPLACE

Oklahoma

OCCUPATION

TeacherFULL
MAIDEN
NAME

MOTHER

Margaret Lacy

RESIDENCE

Ashton, Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

22
(Years)

BIRTHPLACE

Colorado

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 4:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 192

Registrar.

(Signature)

W. J. Graham
Phys.

(Physician or midwife)

Address

Ashton, Idaho

Filed

2-28-1928

192

Ashton, Idaho

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

22

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. No. 5-25 M. 1-19.		RECEIVED APR 2 1928		CERTIFICATE OF DEATH		STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS	
1. PLACE OF DEATH WYOMONT		Registration District No. 102		6		State File No. 60936	
County of ASHTON		Primary Registration District No. (No. St.)				Local Registrar's No.	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME STILLBORN LACY				If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH			
3. SEX MALE		4. COLOR OR RACE WHITE		5. SINGLE, MARRIED, WID-OWED OR DIVORCED		16. DATE OF DEATH FEB. 28/1928 (Month) (Day) (Year)	
6. DATE OF BIRTH FEB. 28th 1928 (Month) (Day) (Year)		7. AGE IF LESS than 1 day how many hrs. or min.? Yrs. Mos. ds.		17. I HEREBY CERTIFY, That I attended deceased from 2-28 1928 to — 19 — , that I last saw h alive on — 19 — , and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows: Placenta Previa (Duration) yrs. mos. ds. Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) James V. Lacy M. D. 1/28 1928 (Address) Ashton Idaho			
8. OCCUPATION (a) Trade, profession or particular kind of work AT H OME (b) General nature of industry, business or establishment in which employed (or employer)		9. BIRTHPLACE (State or Country) ASHTON IDAHO		10. NAME OF Father JAMES. V. LACY		11. BIRTHPLACE OF FATHER (State or Country) WYOMONT OHIO	
12. MAIDEN NAME OF MOTHER MARGERT PARTNER.		13. BIRTHPLACE OF MOTHER (State or Country) COLORADO		14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE JAMES. V. LACY (Informant) (Address) ASHTON IDAHO		18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place In the of death yrs. mos. days. State yrs. mos. ds. Where was disease contracted if not at place of death? Former or usual residence	
15. Filed 2-29 1928 Local Registrar		19. PLACE OF BURIAL OR REMOVAL ASHTON IDAHO		20. UNDERTAKER LEWIS KSIER		DATE OF BURIAL 2/29/29 19 ADDRESS ASHTON IDAHO	

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

296-209-022-764
PLACE OF BIRTH
County of Fremont
City of _____
No. _____ St.

MAR 20 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 160098

Registration District No. 99 State File No. _____

Prim. Registration District No. 2177 Local Registrar's No. 470

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>1</u>	and	Number in order of birth <u>6</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Mar. 9, 1928</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Erythra

Number of child of this mother, including present birth 6 (a) Born alive and now living 4

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Richard Leroy Broadhurst

Residence (Usual place of abode) St. Anthony

If nonresident, give place and State ✓

Color or race White Age at last Birthday 39

Birthplace St. Anthony, Ida. (Years)

(City and State or Country)

Occupation Gen'l laborer

MOTHER
FULL MAIDEN NAME Edna Godfrey

Residence (Usual place of abode) St. Anthony

If nonresident, give place and State ✓

Color or race White Age at last Birthday 36

Birthplace Sydney, Ida. (Years)

(City and State or Country)

Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive ✓ at 10:30 P. M.
on the date above stated.

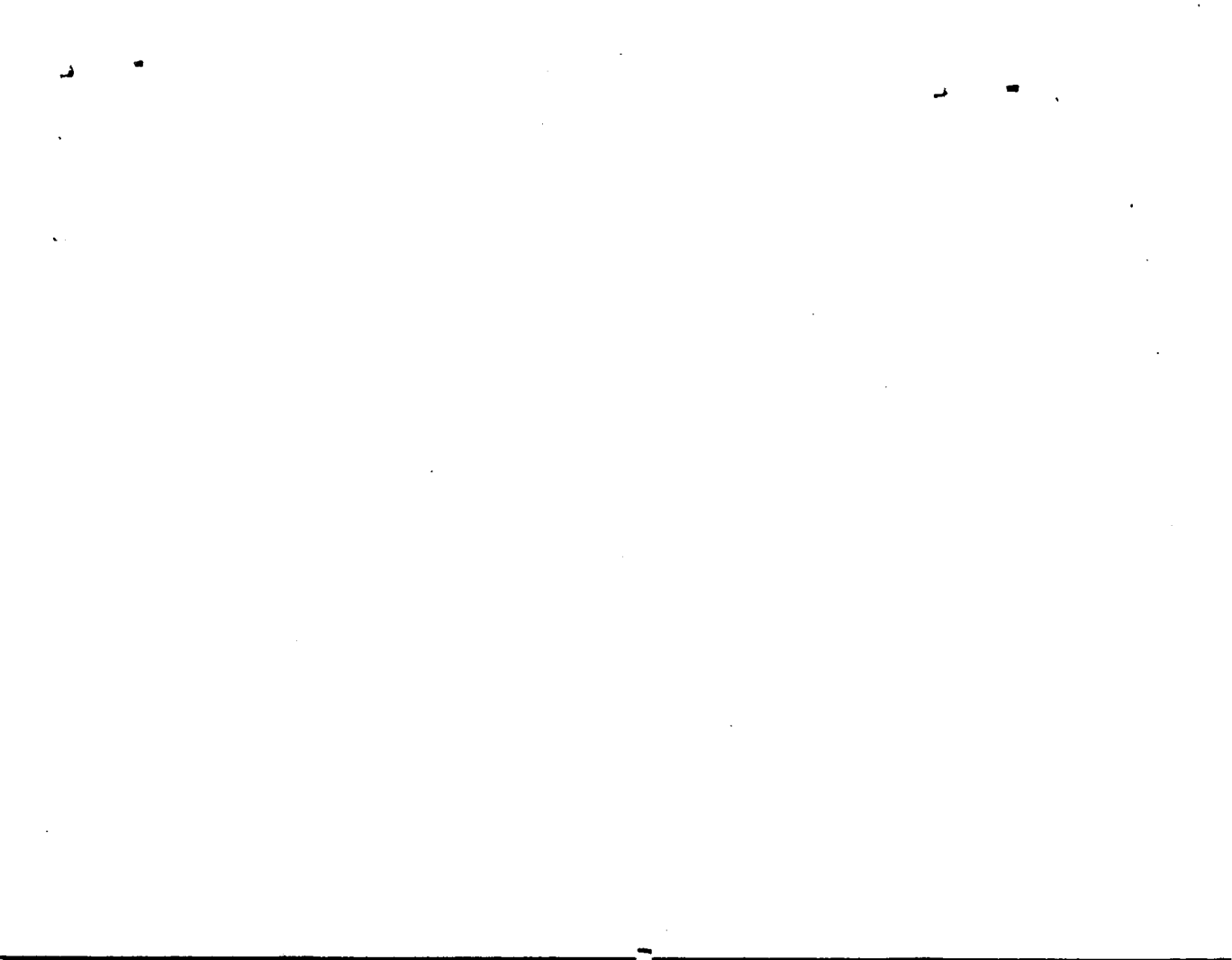
(Signature) P. M. Kelly, M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address St. Anthony, Idaho

Filed 3/17 1928 Wm. Hansen

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 26 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 60928

Local Registrar's No. 237

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Fremont Registration District No. 99
City of St. Anthony Idaho Primary Registration District No. 2177
(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Mar. 9 " 1928

7 AGE Years _____ Months _____ Days 0 If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Anthony Idaho
(State or country)

10 NAME OF FATHER Richard L. Broadhurst

11 BIRTHPLACE OF FATHER (city or town) St. Anthony Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Edna Godfrey

13 BIRTHPLACE OF MOTHER (city or town) Lynman Idaho
(State or country)

14 Informant Richard L. Broadhurst
(Address) St. Anthony Idaho

15 Filed 3/9 1928 COM. Hansen
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar. 9 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar. 9, 1928, to Mar. 9, 1928, that I last saw him alive on Mar. 9, 1928, and that death occurred, on the date stated above, at Mar. 9 m.

The CAUSE OF DEATH* was as follows:

Still-born

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted _____ If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Stillborn

(Signed) P. M. Kelly, M. D.

Mar. 9, 1928 (Address) St. Anthony, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Parker Date of Burial 3/9 1928

20. Undertaker None Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH **RECEIVED APR 9 1928**

STATE OF IDAHO

County of Idaho

DEPARTMENT OF PUBLIC WELFARE

City of Cottonwood 60957

BUREAU OF VITAL STATISTICS

S

No. 244-223-025-313 St. 60957

CERTIFICATE OF BIRTH

Registration District No. 105 State File No. 160152

(If born in hospital or institution
give name.)

Prim. Registration District No. 283 Local Registrar's No. 9

FULL NAME OF CHILD

Stillbirth Sudkamp

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>F</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>March 23</u> 19 <u>28</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living

Born alive but now dead 1 Stillborn

FATHER FULL NAME <u>Joseph H. Sudkamp</u>	MOTHER FULL MAIDEN NAME <u>Gertrude Tacke</u>
--	--

Residence (Usual place of abode) <u>Cottonwood</u>	Residence (Usual place of abode) <u>Cottonwood</u>
--	--

If nonresident, give place and State	If nonresident, give place and State
--------------------------------------	--------------------------------------

Color or race <u>W.</u> Age at last Birthday	Color or race <u>W.</u> Age at last Birthday <u>26</u>
--	--

Birthplace <u>Sigbee Illinois</u> (City and State or Country)	Birthplace <u>Munster, Texas</u> (City and State or Country)
---	--

Occupation <u>Hardware Clerk</u>	Occupation <u>Housewife</u>
----------------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at H. P. M. on the date above stated.

(Signature) Healey Orr M.D.

(Physician or midwife)

Address Cottonwood, Ida

Filed March 30 1928 H. F. Orr per D.B.

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

THIS IS A PRELIMINARY REPORT AND SHOULD NOT BE USED FOR ANY OTHER PURPOSE. IT IS NOT A FINAL REPORT AND SHOULD NOT BE USED FOR ANY OTHER PURPOSE. IT IS NOT A FINAL REPORT AND SHOULD NOT BE USED FOR ANY OTHER PURPOSE.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____
Local Registration No. _____

Sex	Age	Color	Place of Birth	Place of Birth	Place of Birth
Male	1	White	New York	New York	New York

I hereby certify that I attended the birth of this child, who was born on the _____ day of _____, 19____, at _____, New York.

Signature of Physician _____
Name _____

Signature of Midwife _____
Name _____

Signature of Attorney _____
Name _____

Signature of _____
Name _____

Signature of _____
Name _____

Signature of _____
Name _____

Signature of _____
Name _____

FORM V. S. No. 1-28 M. 1-18

RECEIVED APR 9 1928

CERTIFICATE OF DEATH

60952

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 105

County of Idaho

Primary Registration District No. 2183

City of Cottonwood

(No. St.)

File No. 5

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stiebbirth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

March 23 1928
(Month) (Day) (Year)

7. AGE

Yrs. Mos. da.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joseph H. Sudkamp

11. BIRTHPLACE OF FATHER

(State or Country)

Sigel, Illinois

12. MAIDEN NAME OF MOTHER

Bertrude Tacke

13. BIRTHPLACE OF MOTHER

(State or Country)

Munster, Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joseph H. Sudkamp
Cottonwood, Ida.

15.

Filed

Mar. 24 1928

H. F. Orr per D.B.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 23 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Due to Difficult Labor.
Prolapsed placenta, large head.
Prenatal, Prolapsed Placenta.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. F. Orr

M. D.

3/24 1928 (Address) Cottonwood, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cottonwood, Ida.

3-24 1928

20. UNDERTAKER

ADDRESS

H. F. Orr Cottonwood, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

419-225-0246 named
PLACE OF BIRTH
County of Jefferson
City of Payson
No. 160177

RECEIVED APR 4 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

Registration District No. 98 State File No. 160177
Prim. Registration District No. 2176 Local Registrar's No. 52

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Girl</u>	Twin <u>X</u> Triplet <u>X</u> or other? <u>X</u>	and {	Number in order of birth <u>1</u>	Legitimacy <u>Legit</u>	Date of birth <u>Feb. 73</u>	<u>1928</u>
	(To be answered only in event of plural births)				(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver

Number of child of this mother, including present birth 6 (a) Born alive and now living
Born alive but now dead 0 Stillborn 5 (Twins)

FATHER
FULL NAME Wm. A. Marler
Residence (Usual place of abode) Payson Ida
If nonresident, give place and State
Color or race White Age at last Birthday 41 (Years)
Birthplace Idaho
Occupation Laborer

MOTHER
FULL MAIDEN NAME Mary S. Turney
Residence (Usual place of abode) Payson Ida
If nonresident, give place and State
Color or race White Age at last Birthday 38 (Years)
Birthplace England
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive { at Payson M.
on the date above stated. { Stillborn {

(Signature) Sam. F. Price
Physician
(Physician or midwife)

Address Payson Idaho

Filed 4-1 1928 C. F. Harris
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(over)

Mother always suffers
from Brights of Pregnancy

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

369-225-229-371
PLACE OF BIRTH

IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Blaine **RECEIVED APR 9 1928**
City of Troy

CERTIFICATE OF BIRTH

S

No. _____ St. Registration District No. 64 State File No. 160229

Hospital _____ (Primary Registration District No. 2144) Local Registrar's No. _____

FULL NAME OF CHILD (Baby Corkill)

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> }</u> and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>March 23</u> 192 <u>8</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 6

FATHER	MOTHER
FULL NAME <u>Abner Corkill</u>	FULL MAIDEN NAME <u>Oleanor Amy Craine</u>
RESIDENCE <u>Near Troy Ida</u>	RESIDENCE <u>Near Troy Ida</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>70</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>44</u> (Years)
BIRTHPLACE <u>Isle of Man Eng.</u>	BIRTHPLACE <u>Isle of Man Eng.</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>House wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born on the date above stated. March 23, 1928 6:50 P. M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
March 31, 1928
Lucy M. Pickard Registrar.
(Signature) Dr. W. C. Johnson
(Physician or midwife)
Address Moscow Ida.
Filed March 31, 1928 Lucy M. Pickard Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-12

RECEIVED APR 9 1928 CERTIFICATE OF DEATH.

1. PLACE OF DEATH
County of Latah
City of Troy
Registration District No. 64
Primary Registration District No. 2144
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31012
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

(Baby) Corkill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant
(Write the word.)

6. DATE OF BIRTH March 25 1928
(Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day how many _____ hrs. or _____ min. 2
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Infant

9. BIRTHPLACE

(State or Country) Near Troy Ida

10. NAME OF FATHER

Abner Corkill

11. BIRTHPLACE OF FATHER

(State or Country) Ile of Man Eng.

12. MAIDEN NAME OF MOTHER

Eleanor Amy Craine

13. BIRTHPLACE OF MOTHER

(State or Country) Ile of Man Eng.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Abner Corkill(Address) Troy Ida

15. March 31 1928 Lucy M. Pickard
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 25 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from on March 25, 1928 only
that I last saw him alive on re-examination 191
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Dead before labor started. Complicated delivery & extraction with forceps.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) Henry Embury M. D.
1928 (Address) Troy, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hestdale cem. near Troy March 28 1928

20. UNDERTAKER ADDRESS

John J. Pickard Troy Ida

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

164-120-230-419
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Salmon RECEIVED APR 14 1928 CERTIFICATE OF BIRTH

City of Salmon

No. St. Registration District No. 41 State File No. 160292

Hospital..... Primary Registration District No. 116 Local Registrar's No.

FULL NAME OF CHILD..... Poulsen
(Certificate of no value without full name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>No</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>3-20-1928</u> (Month) (Day) (Year)
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What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth <u>One</u>		Number of child of this mother now living, including present birth <u>None</u>	
FULL NAME <u>FATHER William K. Poulsen</u>	FULL NAME <u>MOTHER Eva Martin</u>	FULL NAME	FULL NAME
RESIDENCE <u>Salmon, Ida</u>	RESIDENCE <u>Salmon, Ida</u>	RESIDENCE	RESIDENCE
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>21</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>23</u> (Years)	COLOR	COLOR
BIRTHPLACE <u>Idaho</u>	BIRTHPLACE <u>Idaho California</u>	BIRTHPLACE	BIRTHPLACE
OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife</u>	OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 8:45 P. M. on the date above stated.

(*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.)

Give names added from a supplemental report., 192.....

(Signature) O. Stratton, M.D.
(Physician or midwife)

Address. Salmon, Idaho

Filed. April 10 1928 Clis Bellamy
Registrar. Registrar.

CHILDREN TAKEN FROM A MOTHER AND CHILDREN WITH EXHAUSTED MOTHER
 not more to have various children in the same place to have to be taken to the same place

PLACE OF BIRTH

DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 STATE OF IOWA

CERTIFICATE OF BIRTH

180388

No. _____
 Registration District No. _____
 State File No. _____
 Loc. of Registrar's No. _____
 Primary Registration District No. _____
 (Hospital) _____

TRUE NAME OF CHILD

(Certificate of no value without full name of child)
 Sex of child _____
 Date of birth _____
 Date of birth _____
 (Month) _____
 (Year) _____

Where registration certificate was used in the _____
 Name of child of this mother, including present birth _____
 Name of child of this mother, including present birth _____
 FATHER _____
 MOTHER _____
 FULL NAME _____
 RESIDENCE _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 BIRTHPLACE _____
 OCCUPATION _____
 COLOR _____
 AGE AT LAST BIRTHDAY _____
 BIRTHPLACE _____
 OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
 At _____
 On _____
 When there was no attending physician or midwife, the father, mother, or other person should make this return.
 A stillborn child is one that neither breathes nor shows other evidence of life after birth.
 Give names added from a supplemental report.
 102
 Registrar _____
 Registrar _____

RECEIVED APR 14 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **61037**

PLACE OF DEATH

County of **Lephi**City of **Salmon**

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OF HAIR **White** 5. Single, Married, Widowed, or Divorced (write the word) **Single**5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of **✓**6. DATE OF BIRTH (month, day and year) **3-20-1928**7. AGE **Full born** Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **✓**(b) General nature of industry, business, or establishment in which employed (or employer) **✓**(c) Name of employer **✓**9. BIRTHPLACE (city or town) **Salmon, Ida**
(State or country)10. NAME OF FATHER **William L. Poulsen**11. BIRTHPLACE OF FATHER (city or town) **Idaho**
(State or Country)12. MAIDEN NAME OF MOTHER **Eva Martin**13. BIRTHPLACE OF MOTHER (city or town) **California**
(State or Country)14. Informant **O. J. Shatto**
(Address) **Salmon, Idaho**15. Filed **4/10**, 1928 **Chas. Bellamy**
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **April 10** 1928
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
_____, 19____, to _____, 19____
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH was as follows:**Full born, cause
unknown.**
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? **✓**Did an operation precede death? **No** Date ofWas there an autopsy? **No**What test confirmed diagnosis?
3/21 (Signed) **O. J. Shatto** M. D.
1928 (Address) **Salmon, Ida**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal **Salmon, Ida.** Date of Burial **3/21** 192820. Undertaker **Wm. L. Poulsen** Address **Salmon, Ida**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

689-129034-363
PLACE OF BIRTH

RECEIVED APR 4 1928

STATE OF IDAHO

County of minidoka

DEPARTMENT OF PUBLIC WELFARE

City of minidoka

BUREAU OF VITAL STATISTICS

No. _____ St. _____

CERTIFICATE OF BIRTH

S

Registration District No. 19 State File No. 160360

(If born in hospital or institution
give name.)

Prim. Registration District No. 2011 Local Registrar's No. 40

FULL NAME OF CHILD Stillborn (name not known)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in order of birth of plural births)	and	Number in order of birth (To be answered only in order of plural births)	Legiti- mate <u>yes</u>	Date of birth <u>Mar. 29</u> 19 <u>28</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME <u>William R. White</u>	FULL MAIDEN NAME <u>Agnes May Colbert</u>

Residence (Usual place of abode) minidoka minidoka, Ida.

If nonresident, give place and State _____

Color or race white Age at last Birthday 39 white Age at last Birthday 23
(Years) (Years)

Birthplace Regina, Ida. Chicago, Ills.
(City and State or Country) (City and State or Country)

Occupation Catcher Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 11:45 a. M.
on the date above stated.

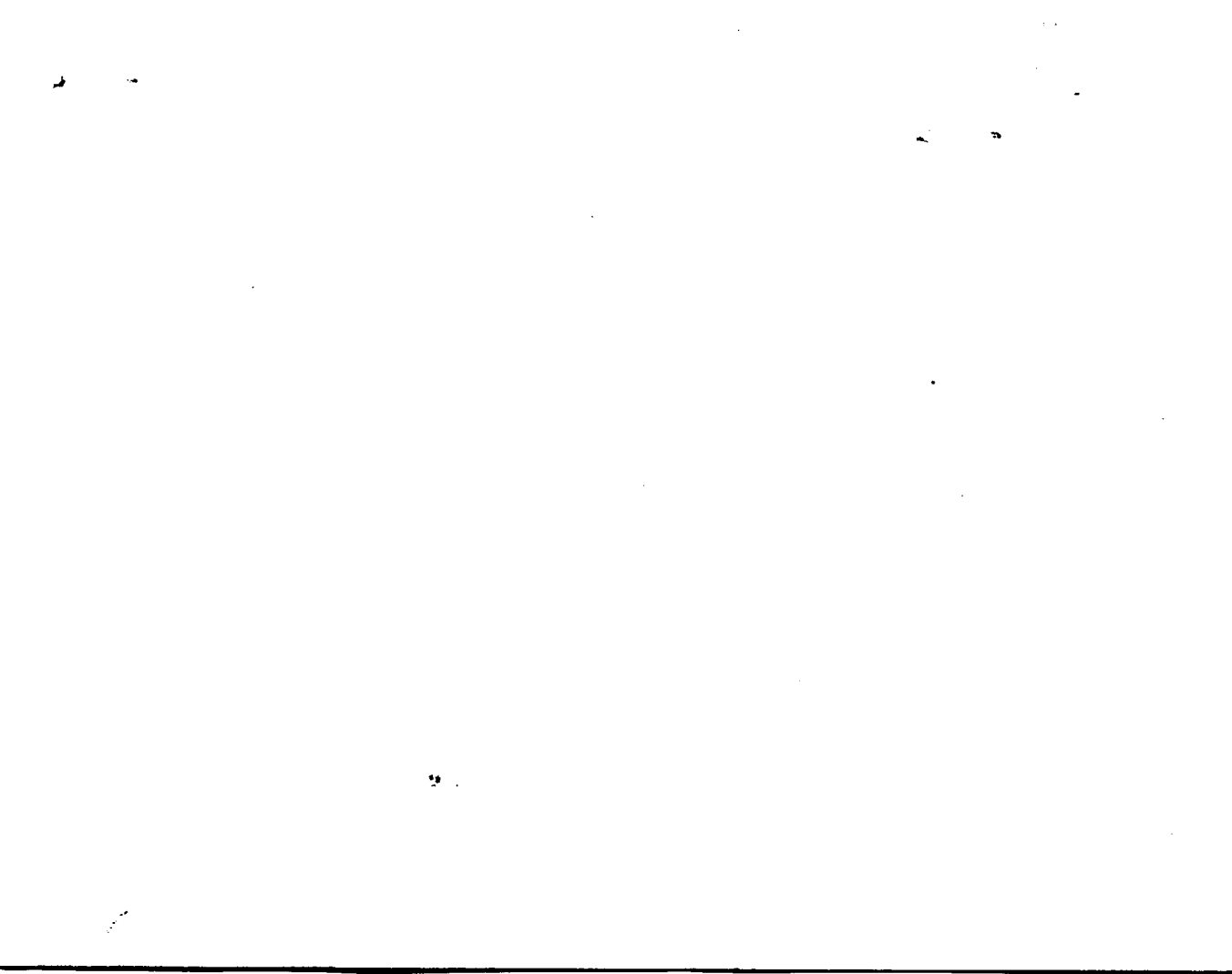
(Signature) Edt. E. Moore

(Physician or midwife)

Address Regina, Ida.

Filed 3-30-28 Edt. E. Moore
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 4 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 51059Local Registrar's No. 3

PLACE OF DEATH

County of Minidoka
City of Minidoka

Registration District No. 19Primary Registration District No. 2215

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Stillborn White

(a) Residence. No. _____

St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) March 29, 1928

7 AGE Years Months Days
1 If LESS than
day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Minidoka Ida
(State or country)10 NAME OF FATHER Milburn R. White11 BIRTHPLACE OF FATHER (city or town) Reynolds, Ida
(State or country)12 MAIDEN NAME OF MOTHER Agnes May Colbert13 BIRTHPLACE OF MOTHER (city or town) Chicago Ill.
(State or country)14 Informant Mrs. Melvyn R. White
(Address) Minidoka, Ida15 Filed 4-2, 1928 E. E. Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 29 1928
(Month) (Day) (Year)
Stillborn

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Cause not known
8" minute gestation
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) E. E. Elmore, M. D.
4-2, 1928 (Address) Reynolds, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal _____ Date of Burial _____
19

20. Undertaker _____ Address _____
none

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic Interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

265-127-234-154
PLACE OF BIRTH RECEIVED APR 7 1928 STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
S -
160366

County of Minidoka
City of Rupert
No. _____ St. _____
Registration District No. 19 State File No. 1
Prim. Registration, District No. 2013 Local Registrar's No. 46
FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Mar 27</u> (Month) (Day) (Year) <u>1928</u>
--------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>Jash Sweat</u> Residence (Usual place of abode) <u>Albion Ida</u> If nonresident, give place and State _____ Color or race <u>White</u> Age at last Birthday <u>43</u> (Years) Birthplace <u>Utah</u> (City and State or Country) Occupation <u>Farmer</u>	MOTHER FULL MAIDEN NAME <u>Mary Anderson</u> Residence (Usual place of abode) <u>Albion Ida</u> If nonresident, give place and State _____ Color or race <u>White</u> Age at last Birthday <u>39</u> (Years) Birthplace <u>Utah</u> (City and State or Country) Occupation <u>Housewife</u>
--	---

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive
Stillborn } at 5 20 P. M.
on the date above stated.

(Signature) E. E. E. E. E.
M. D.,
(Physician or midwife)

Address Rupert
Filed 4-3 1928 E. E. E. E. E.
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

UNITED STATES DEPARTMENT OF JUSTICE
BUREAU OF PRISON STATISTICS
WASHINGTON, D. C.

Country of birth _____
Date of birth _____
Place of birth _____
Occupation _____

Registration number No. _____
Date of registration _____
Place of registration _____

ALL NAMES OF CHILD

First name _____
Middle name _____
Last name _____
Date of birth _____
Place of birth _____

What prophylactic was used to prevent Venereal Disease?

Number of visits of the mother including present birth _____
Date of birth _____

First name _____
Middle name _____
Last name _____
Date of birth _____
Place of birth _____

First name _____
Middle name _____
Last name _____
Date of birth _____
Place of birth _____

First name _____
Middle name _____
Last name _____
Date of birth _____
Place of birth _____

CHARACTERISTICS OF ATTENDING PHYSICIAN OR MIDWIFE

First name _____
Middle name _____
Last name _____
Date of birth _____
Place of birth _____

When there was no attending physician
or midwife, then the delivery was made
etc. should make this return. A stillborn
child is one that neither physician nor
other evidence of life was noted.

Address _____
Telephone _____

RECEIVED APR 4 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 61068

PLACE OF DEATH

County of MinidokaCity of RupertRegistration District No. 1Primary Registration District No. 2015

(No. _____)

Local Registrar's No. 34

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Sweet

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white5 Single, Married, Widowed,
or Divorced (write the word)Child

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

Mar. 27, 1928

7 AGE

Years

Months

Days

If LESS than

1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of workStillborn(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Rupert, Ida

10 NAME OF FATHER

Josh Sweet11 BIRTHPLACE OF FATHER (city or town)
(State or country)Utah

12 MAIDEN NAME OF MOTHER

Mary Anderson13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Utah

14

Informant
(Address)Mrs. Josh Sweet
Idaho

15

Filed

4-31928Ed E. Moore

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar. 27
(Month) (Day)1928
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Stillborn

19____

that I last saw him alive on 19____

and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Stillborn at termCONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

Chronic Nephritis in
mother

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed)

Ed E. Moore M. D.4-3 1928 (Address) Rupert, Ida.*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS and NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

19

20. Undertaker

none

Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

294-126-036-496
PLACE OF BIRTH
County of Malad
City of Malad

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 160389

No. Community St.
(If born in hospital or institution
give name.)

Registration District No. 3726 State File No. 50

Prim. Registration District No. 2064 Local Registrar's No. 50

FULL NAME OF CHILD

Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Mar 26</u> 19 <u>28</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Clyde G. Brunson
Residence (Usual place of abode) Malad, Ida

MOTHER
FULL MAIDEN NAME Rachel Miffline
Residence (Usual place of abode) Malad, Ida

If nonresident, give place and State
Color or race White Age at last Birthday 27 (Years)
Birthplace Hillmore, Wt.
(City and State or Country)
Occupation Student

If nonresident, give place and State
Color or race White Age at last Birthday 22 (Years)
Birthplace Malad, Ida
(City and State or Country)
Occupation School Teacher

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 6:30 P. M.
on the date above stated.

(Signature) [Signature]

(Physician or midwife)

Address Malad, Ida

Filed 3/31 1928

Registrar. [Signature]

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Day

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

413-203-640-515
PLACE OF BIRTH

RECEIVED APR 13 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Shoshone
City of Wallace

CERTIFICATE OF BIRTH 160444

No. _____ St. _____ Registration District No. 21 State File No. _____

Hospital Wallace Primary Registration District No. 10 Local Registrar's No. 16

FULL NAME OF CHILD Baby Dalton
(Certificate of no value without full name of child)

Sex of Child <u>female</u>	Twin Triplet or other? <u> }</u>	and { Number in order of birth <u>Ind.</u>	Legitimate? <u>yes</u>	Date of birth <u>March 3</u> 192 <u>8</u> (Month) (Day) (Year)
----------------------------	----------------------------------	--	------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth <u>2</u>	Number of child of this mother now living, including present birth <u>1</u>
--	---

FATHER FULL NAME <u>Eduard Elvey Dalton</u> RESIDENCE <u>Wallace</u> COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>31</u> (Years) BIRTHPLACE <u>Burke</u> OCCUPATION <u>Machinist</u>	MOTHER FULL MAIDEN NAME <u>Charlotte Louise Van Horn</u> RESIDENCE <u>Wallace</u> COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>23</u> (Years) BIRTHPLACE <u>Wisconsin</u> OCCUPATION <u>Housewife</u>
---	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8:40 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1928

(Signature) James R. Brown
(Physician or midwife)

Address _____
Filed Mar 15 1928 J. L. Quigley
Registrar.

100144

No. _____ Registration District No. _____ State of _____
 Hospital No. _____ Birth Registration District No. _____ Local Registrar's No. _____

[illegible]

FATHER		MOTHER	
NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
Full name of father, including present birth		Full name of mother, including present birth	
What institution was used in (over)			

[illegible]

I hereby certify that I attended the birth of this child, who was { Name } at { Address } on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

Registered
 Filed
 1932
 Address
 (Physician or midwife)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 13 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 61094

County of Shoshone

Registration District No. 70

Local Registrar's No. 26

City of Wallace

Primary Registration District No. 1011

(No. Wallace)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME

Baby Dalton

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

None

6 DATE OF BIRTH (month, day and year)

Stillborn

7 AGE Years Months Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Wallace Idaho

10 NAME OF FATHER

Edward Dalton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Purke Idaho

12 MAIDEN NAME OF MOTHER

Charlotte Van horne

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Wisconsin

14 Informant Edward Dalton

(Address)

Wallace Idaho

15 Filed

Mar 5 1928

J. L. Quigley

Regist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March

3

1928

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

_____ 19_____, to _____ 19_____,

that I last saw him alive on _____ 19_____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born Female

7 1/2 mos fetus

mother with eclampsia

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) James R. Mann

_____ M. D.

1928 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Wallace Idaho

March 5 1928

20. Undertaker J. A. Bever

Address

Ward Undertaking Co

Wallace Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children*not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

393-224.001-395
PLACE OF BIRTH

County of Ada RECEIVED MAY 8 1928

City of Bain

No. 1417 n. 24 St.

Salvation Army
(If born in hospital or institution
give name.)

Registration District No. 2 State File No. 360574

Prim. Registration District No. 1004 Local Registrar's No. 155

FULL NAME OF CHILD Jessie Littlejohn (Stillborn)
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimacy <u>m</u>	Date of birth <u>April 24</u> 1928 (Month) (Day) (Year)
-------------------------------	---	--------------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? C

Number of child of this mother, including present birth one (a) Born alive and now living none

Born alive but now dead none Stillborn one

FATHER
FULL NAME Jack Bohn
Residence (Usual place of abode) Helper
If nonresident, give place and State Utah
Color or race white Age at last Birthday —
Birthplace U. S. (Years)
(City and State or Country)
Occupation Rail Road Engineer

MOTHER
FULL MAIDEN NAME Jean Gochrene Littlejohn
Residence (Usual place of abode) Price
If nonresident, give place and State Utah
Color or race white Age at last Birthday 21
Birthplace Scotland (Years)
(City and State or Country)
Occupation Theater usher

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 5:45 A. M.
on the date above stated.

(Signature) Edna M. Mendenhall
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address —
Filed 4-26- 19 28 Taula McDougal
Registrar.

SHOWED THAT THE CHILD WAS BORN IN THE UNITED STATES OF AMERICA AND THAT THE CHILD WAS NOT A NATURALIZED CITIZEN OF THE UNITED STATES OF AMERICA. THE CHILD WAS BORN IN THE UNITED STATES OF AMERICA AND WAS NOT A NATURALIZED CITIZEN OF THE UNITED STATES OF AMERICA.

PLACE OF BIRTH

DATE OF BIRTH

BUREAU OF VITAL STATISTICS
DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF BIRTH

4-80074

Registration District No. _____ State File No. _____

(If born in hospital or institution give name)

FULL NAME OF CHILD

(If full name including the word "daughter" for girls or "son" for boys)

Sex of Child	Age at Birth	Month	Day	Date of Birth
Male	_____	_____	_____	_____

What prophylactic was used to prevent rhabdism? _____

Number of child of this mother, including previous births, _____ (If born alive and now living _____)

NAME _____

Residence (Usual place of abode) _____

It is certified that the child was born _____

Color of hair _____ (If not stated, give place and date)

Place of birth _____ (City and State or Country)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____

(Signature) _____

Address _____

Filed _____

*Where there was no attending physician or midwife, then the father, mother, etc., should make this return. A statement that it is one that neither physician nor shows other evidence of life after birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

61179

State File No.

Place of Death
County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
(No. Salvation Army Rescue Home.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 103

2. FULL NAME Juanita Littlejohn.
Boise, Idaho. St.

(a) Residence. No. Boise, Idaho. St. Boise, Idaho.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female. 4. COLOR OR RACE White. 5. Single, Married, Widowed, or Divorced (write the word) Single.
6a. If married, widowed, or divorced HUSBAND of
(or) WIFE of _____
6. DATE OF BIRTH (month, day and year) April 24th 1928.
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

10. NAME OF FATHER Jack Bohn.

11. BIRTHPLACE OF FATHER (city or town) U.S.
(State or Country)

12. MAIDEN NAME OF MOTHER Jean Cochran Littlejohn.

13. BIRTHPLACE OF MOTHER (city or town) Scotland.
(State or Country)

14. Informant Edward McBratney.
(Address) Boise, Idaho.

15. Filed 4/24/28, 19 28 Kulla M. Donay
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 24th 1928.

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24, 1928, to Apr 24, 1928,
that I last saw her alive on Apr 24, 1928,
and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Still born.

(duration) yrs. mos. ds.
CONTRIBUTORY Fracture
(Secondary) cause unknown.

Worker Had Fracture, Expectation
18. Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of _____Was there an autopsy? noWhat test confirmed diagnosis? none

(Signed) Dr. J. M. Donay, M. D.
4/24/28, 19 28 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 4/25/28 19 28

20. Undertaker Wm. McBratney. Address Boise, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

316-113-002-114

PLACE OF BIRTH

County of Bannock

City of Pocatello

No. R.R.I St.

Pocatello General

(If born in hospital or institution give name.)

RECEIVED APR 18 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 160640

Registration District No. 28 State File No.

Prim. Registration District No. 2661 Local Registrar's No. 8605

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>---</u> (To be answered only in event of plural births)	and { Number in order of birth <u>---</u>	Legitimate? <u>Yes</u>	Date of birth <u>3/13/28</u>	19 <u>19</u>
				(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum? IS AgNO₃

Number of child of this mother, including present birth I (a) Born alive and now living

Born alive but now dead --- Stillborn I

FATHER

FULL NAME James Clayborn Lawson

Residence (Usual place of abode) R.R.I Pocatello
Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 48

Birthplace Facewell Virginia (Years)

(City and State or Country)
Occupation Teamster

MOTHER

FULL MAIDEN NAME Mary Stella Jamison

Residence (Usual place of abode) R.R.I Pocatello
Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 42

Birthplace Facewell Virginia (Years)

(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn born alive at 8:30 A. M. on the date above stated.

(Signature) Dr. J. Howard

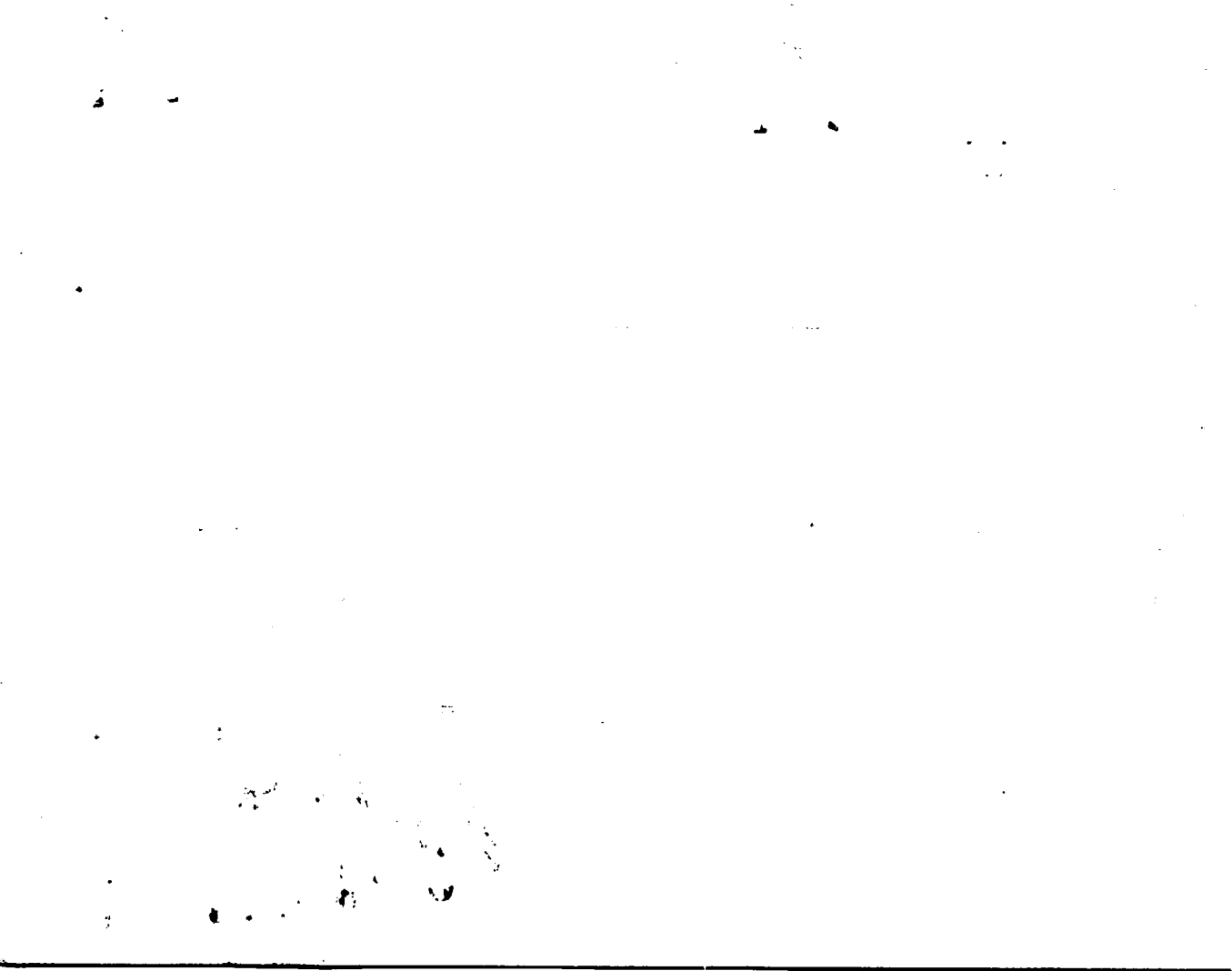
(Physician or midwife)

Address Pocatello, Idaho

Filed 4/1 19 28 W. Young

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 16 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 60844

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 261
(No. GENERAL HOSPITAL)

Local Registrar's No. 5233

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME INFANT LAWSON

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. Single, Married, Widowed, or Divorced (write the word) SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) MAR. 13, 1928

7. AGE 3 Years still born Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) POCATELLO, IDA.
(State or country)

10. NAME OF FATHER J. C. LAWSON

11. BIRTHPLACE OF FATHER (city or town) VIRGINIA
(State or Country)

12. MAIDEN NAME OF MOTHER MARY S. JAMISON

13. BIRTHPLACE OF MOTHER (city or town) VIRGINIA
(State or Country)

14. Informant J. C. LAWSON
(Address) SOUTH POCATELLO

15. Filed 3/14, 1928 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH MAR. 13, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 13, 1928 to Mar 13, 1928
that I last saw him alive on Still born
and that death occurred, on the date stated above, at 8:00 a.m.
The CAUSE OF DEATH* was as follows:

Difficult labor
Exhaustion of child, long difficult labor
(Band's ring) (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical
(Signed) H. F. Howard
3/13, 1928 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

MOUNTAIN VIEW CEMETERY MAR. 14, 1928

20. Undertaker Address

ARTHUR W. HALL POCATELLO.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

155-114-003-155
PLACE OF RECEIVED MAY 4 1928

County of Bannock
City of Arimo
No. 5 St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 84 State File No. 160675

(If born in hospital or institution
give name.)

Prim. Registration District No. 2161 Local Registrar's No. 475

FULL NAME OF CHILD

Baby Jenkins

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>April 14</u> 19 <u>28</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? to no name

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 1 Stillborn one this one

FATHER
FULL NAME Otto Jenkins

MOTHER
FULL MAIDEN NAME Verna M. Jensen

Residence (Usual place of abode) Armo Ida

Residence (Usual place of abode) Armo Ida

If nonresident, give place and State

If nonresident, give place and State

Color or race White Age at last Birthday 21
(Years)

Color or race White Age at last Birthday 17
(Years)

Birthplace Robin Idaho
(City and State or Country)

Birthplace Menden Utah
(City and State or Country)

Occupation laborer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive 5:30 P M.
on the date above stated. Stillborn at 7:30 P M.

(Signature) B. A. Rich

(Physician or midwife)

Address Lava Hot Springs Ida

Filed 4/30 1928 Wm. J. G. Felt

Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

UNKNOWN PERSONS ARE BEING SEARCHED FOR BY THE BUREAU OF INVESTIGATION OF THE DEPARTMENT OF JUSTICE. IF YOU HAVE ANY INFORMATION CONCERNING ANY OF THESE PERSONS, PLEASE CONTACT THE BUREAU OF INVESTIGATION AT 400 ...

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. _____
Local Health Officer No. _____
Date of Birth _____

Full Name of Child _____
Sex _____
Date of Birth _____
Place of Birth _____
Parents' Names _____

It is hereby certified that the foregoing information was used to prepare the birth record for the child named above.
Name of Child _____
Date of Birth _____
Place of Birth _____
Parents' Names _____

Residence of Child _____
Is the child now living with the mother? _____
City and State of Residence _____
Date of Birth _____
Place of Birth _____
Parents' Names _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was _____
(Signature) _____

Where there was no attending physician or midwife, then the father, mother, or other person should make this return. A statement which is one that neither father nor mother or other person should make after birth.

Address _____
Filed _____

RECEIVED MAY 4 1928

RECEIVED MAY 4 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 61241

Local Registrar's No. 118

County of Bannock Registration District No. 84
City of Arino Primary Registration District No. 2161

(No. _____)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Otto Jenkins Jr

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) April 14, 1928

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min. Stillbirth

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer none

9 BIRTHPLACE (city or town) Arino Idaho
(State or country)

10 NAME OF FATHER Otto Jenkins

11 BIRTHPLACE OF FATHER (city or town) Robin Idaho
(State or country)

12 MAIDEN NAME OF MOTHER Verna M. Jensen

13 BIRTHPLACE OF MOTHER (city or town) Menden Utah
(State or country)

14 Informant C. A. Rich M.D. Gyp Butte
(Address) Lava Hot Springs

15 Filed 4/30, 1928 Mrs G. G. Felt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 14 1928
(Month) (Day) (Year)

17 HEREBY CERTIFY, That I attended deceased from April 14, 1928, to April 14, 1928, that I last saw him alive on Stillbirth, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Disproportionate size of
Baby compared to mother
Instrumental Delivery
Term Duration (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY none
(Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____
Did an operation precede death? no Date of _____
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) C. A. Rich M. D.
4-15-, 1928 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal _____ Date of Burial _____ 19____

20. Undertaker _____ Address _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED MAY 7 1928

County of Bmyhan
City of Aberdeen

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. 639-117-006-295 St.

Registration District No. 116

State File No. 160695

(If born in hospital or institution
give name.)

Prim. Registration District No. 2/13

Local Registrar's No. 20

FULL NAME OF CHILD unnamed

Olin

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>9 17</u> 19 <u>28</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 5 (a) Born alive and now living 3

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME James Robert Olin

MOTHER
FULL MAIDEN NAME Mary Evelyn King

Residence (Usual place of abode) Aberdeen Idaho

Residence (Usual place of abode) Aberdeen Idaho

If nonresident, give place and State

If nonresident, give place and State

Color or race white Age at last Birthday 37

Color or race white Age at last Birthday 36

Birthplace Breal Springs, Illinois (City and State or Country)

Birthplace Black Hills, South Dakota (City and State or Country)

Occupation carpenter

Occupation W. W.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 730 P M.
on the date above stated.

(Signature) J. Olin

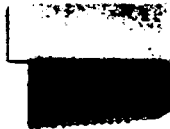
(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address Aberdeen, Ida

Filed 4/18 1928

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 7 1928

 STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **61256**

PLACE OF DEATH

 County of Bingham
 City of Meridian

CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

Local Registrar's No. 6
 (No.)
 (If death occurred in a hospital or institution, give its name instead of street and number.)
2. FULL NAME Still born Oliver

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

 3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

 5a If married, widowed, or divorced
 HUSBAND of
 (or) WIFE of
6 DATE OF BIRTH (month, day and year) ap 17, 1928
 7 AGE Years Months Days
 If LESS than 1 day, hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Meridian Idaho
(State or country)10 NAME OF FATHER James S. Oliver11 BIRTHPLACE OF FATHER (city or town) Coal Springs Illinois
(State or country)12 MAIDEN NAME OF MOTHER Mary Evelyn King13 BIRTHPLACE OF MOTHER (city or town) Black Hills South Dakota
(State or country)14 Informant J. S. Oliver
(Address) Meridian Ida15 Filled ap 18 28 McMurtre
Registrar

MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH ap 17 28
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended deceased from
 _____, 19____, to _____, 19____,
 that I last saw h. _____ alive on _____, 19____,
 and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born
37 weeks of uterine gestation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) McMurtre, M. D.ap 12 19 28 (Address) Meridian Ida
 *State the DISEASE CAUSING DEATH, or in deaths from VIO-
 LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
 and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

 19 Place of Burial, Cremation, or Removal on farm - Meridian Ida Date of Burial ap 17 19 28
20. Undertaker Quenches Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

946-108-006-314
PLACE OF BIRTH

RECEIVED MAY 8 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Shoshone

City of Shoshone

CERTIFICATE OF BIRTH 160722

No. 1 St. 121 Registration District No. 121 State File No. 149

Hospital Primary Registration District No. 2144 Local Registrar's No. 149

FULL NAME OF CHILD Orick Grifelt

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and { Number in order of birth Legitimate? yes Date of birth Apr 6 1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Alex Grifelt
RESIDENCE Shelley Idaho
COLOR W AGE AT LAST BIRTHDAY 32 (Years)
BIRTHPLACE Lynnman Utah
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Erma Lamb
RESIDENCE Shelley Idaho
COLOR W AGE AT LAST BIRTHDAY 20 (Years)
BIRTHPLACE Vernal Utah
OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 4:25 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report

(Signature)

Address

(Physician or midwife)

Registrar

Filed

1928

Registrar

This child was born
"breach" - was seen by me
25 min after birth. had
shown no signs of life.
By using artificial respiration
the heart was active 1 hr & 15 min.
when all efforts failed to keep
it going. It did not breath
alone at any time nor
show any muscular action.
F.G.R.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. **61257**

PLACE OF DEATH
County of Blaine
City of Shelley

Registration District No. 121
Primary Registration District No. 2194

Local Registrar's No. 40

(No. ...)
(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Dick Gufelt
(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS
1. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Spent
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)
7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley Idaho

10. NAME OF FATHER Oliver Gufelt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lewiston Mich

12. MAIDEN NAME OF MOTHER Berna Lamm

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bernal Utah

14. Informant Klem Gufelt
(Address)

15. Filed Apr 7 1928 M. W. L. - D. A. L. - D. A. L.
Registrar

MEDICAL CERTIFICATE OF DEATH
16. DATE OF DEATH April 8 28
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from April 8 28 to April 8 28
that I last saw alive on April 8 28
and that death occurred, on the date stated above, at 5:20 a. m.

The CAUSE OF DEATH* was as follows:
Born full term and
mother alone - never
breathed heart kept going
by artificial respiration
CONTRIBUTORY (Secondary) Stillborn
(duration) yrs. mos. ds.

18. Where was disease contracted
If not at place of death?
Did an operation precede death? Yes Date of

Was there an autopsy? Yes
What test confirmed diagnosis?

(Signed) Apr 8 7 M. W. L. - D. A. L. - D. A. L. M. D.
(Address) Shelley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley Idaho Date of Burial Apr 8 - 1928

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED APR 20 1928

PLATE OF IDAHO
County of Blaine
City of Idaho Falls, Idaho.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. 72-128010-799 St.

Registration District No. 23 State File No. 160800

(If born in hospital or institution
give name.)

Prim. Registration District No. 2107 Local Registrar's No. 162

FULL NAME OF CHILD Stillbirth ✓
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin <u>✓</u> Triplet <u>✓</u> or other?	Number in order of birth <u>#2</u>	Legitimate? <u>Yes</u>	Date of birth <u>Feb. 28</u> , 19 <u>28</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? Neo Silvol 20%

Number of child of this mother, including present birth 6 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 6

FATHER
FULL NAME Chas. F. Russell

MOTHER
FULL MAIDEN NAME Beatrice Price.

Residence (Usual place of abode) Ucon, Idaho.

Residence (Usual place of abode) Ucon, Idaho.

If nonresident, give place and State

If nonresident, give place and State

Color or race White Age at last Birthday 36 (Years)

Color or race white Age at last Birthday 30 (Years)

Birthplace Draper, Utah.
(City and State or Country)

Birthplace Draper, Utah.
(City and State or Country)

Occupation Farmer.

Occupation Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn ~~Born alive~~ at 12:45 PM.
on the date above stated.

(Signature) [Signature]
(Physician or midwife)

Address Idaho Falls, Idaho.

Filed 4-21-28 1928 C. E. [Signature]
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



10 D

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED APR 1928
OFFICE OF BIRTH BONNEVILLE
IDAHO
PUBLIC WELFARE
STATISTICS

S

City of Idaho Falls, Idaho.

CERTIFICATE OF BIRTH

160801

No. 72-2281010-799 St.

Registration District No. 33 State File No.

(If born in hospital or institution give name.)

Prim. Registration District 22-1-1 Local Registrar's No. 15-9

FULL NAME OF CHILD Stillbirth.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin <u>✓</u> Triplet <u>✓</u> or other <u>✓</u> (To be answered only in event of plural births)	Number in order of birth <u>#1</u>	Legitimate? <u>Yes</u>	Date of Birth <u>Feb. 28, 1928</u> (Month) (Day) (Year)
----------------------------	---	------------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? Neo Silvol 20%

Number of child of this mother, including present birth 5 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 5

FATHER
FULL NAME Chas F. Russell

Residence (Usual place of abode) Ucon, Idaho.

If nonresident, give place and State

Color or race white Age at last Birthday 36 (Years)

Birthplace Draper, Utah. (City and State or Country)

Occupation Farmer.

MOTHER
FULL MAIDEN NAME Beatrice Price.

Residence (Usual place of abode) Ucon, Idaho.

If nonresident, give place and State

Color or race white Age at last Birthday 30 (Years)

Birthplace Draper, Utah. (City and State or Country)

Occupation Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 10:30 A. M. on the date above stated. stillborn.

(Signature) [Signature]

(Physician or midwife)

Idaho Falls, Idaho.

Address [Signature]

Filed Mar 1 1928 [Signature]

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Don

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

412-11-018-993
PLACE OF BIRTH

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Clearwater

City of Elk River

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 91 State File No. 160925

Hospital Elk River Hosp. Primary Registration District No. 2168 Local Registrar's No. 169

FULL NAME OF CHILD not named (stillborn)

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>April 11, 1928</u> (Month) (Day) (Year)
-----------------------------	---	--------------------------------------	---------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth one Number of child of this mother now living, including present birth none

FATHER	MOTHER
FULL NAME <u>Arthur Henry Mast.</u>	FULL MAIDEN NAME <u>Edith Angeline Rickel</u>
RESIDENCE <u>Elk River, Id.</u>	RESIDENCE <u>Elk River, Id.</u>
COLOR <u>Wh.</u>	COLOR <u>Wh.</u>
AGE AT LAST BIRTHDAY <u>21</u> (Years)	AGE AT LAST BIRTHDAY <u>19</u> (Years)
BIRTHPLACE <u>Urbana Ohio</u>	BIRTHPLACE <u>Idaho.</u>
OCCUPATION <u>Laborer</u>	OCCUPATION <u>Housewife.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was (Stillborn) at 5:00 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

OM Mastel

(Physician or ~~midwife~~)

Address Elk River, Idaho

Filed May 2, 1928 Mildred Hamlin

Registrar.

Registrar.



Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Elk River
City of Elk River

Registration District No. 71
Primary Registration District No. 2168
(No. _____, _____ St.)

State of Idaho :
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 61362
Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Mast

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Writes the word.)

6. DATE OF BIRTH April 11 1928
(Month) (Day) (Year)

7. AGE stillborn IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Elk River, Idaho.

10. NAME OF FATHER Arthur Henry Mast.

11. BIRTHPLACE OF FATHER
(State or Country) Urbana Ohio.

12. MAIDEN NAME OF MOTHER Edith Angeline Rickel.

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A.H. Mas+
(Address) Elk River, Idaho.

15. Filed 1928
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 11 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191
that ~~I~~ never saw h. alive on 191
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Eclampsia of mother. Baby premature
(Secondary) estimated to be 7 months.
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Wm. D. [Signature] M. D.
4/11 1928 (Address) Elk River, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital)," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

695-117-
PLACE OF BIRTH
County of Sevier
City of Cottonwood
No. _____ St.

(If born in hospital or institution
give name.)

RECEIVED MAY 10 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 105 State File No. 160997

Prim. Registration District No. 2183 Local Registrar's No. 23

FULL NAME OF CHILD

Still born Finley

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Apr 17</u> 192 <u>8</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? x

Number of child of this mother, including present birth 6 (a) Born alive and now living 5

Born alive but now dead 0 Stillborn 1

FATHER

FULL NAME R. D. Finley

Residence (Usual place of abode) Cottonwood

If nonresident, give place and State _____

Color or race White Age at last Birthday 41 (Years)

Birthplace Tennessee
(City and State or Country)

Occupation Electrician

MOTHER

FULL MAIDEN NAME Leahy Pearson

Residence (Usual place of abode) Cottonwood

If nonresident, give place and State _____

Color or race White Age at last Birthday 33 (Years)

Birthplace Washington
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { born alive } at 330 P. M.
on the date above stated. { Stillborn }

(Signature) E. C. Woodard M. D.

(Physician or midwife)

Address Cottonwood 2nd

Filed Apr 30 1928 H. F. Orr per D. B.
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

NOTICE TO THE PUBLIC: This is to certify that the above named child is the legitimate child of the parents named herein and that the same has been born in wedlock and is not a bastard. This is to certify that the above named child is the legitimate child of the parents named herein and that the same has been born in wedlock and is not a bastard.

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 102
Birth Registration District No. 2183
State of Illinois
It is hereby certified that the word "Child" has been used.

Child's Name at Birth Stella Marie
Sex of Child Female
Date of Birth May 10 1907
Place of Birth Chicago, Ill.
If not prophylactic was used to prevent (Syphilis, Venereal Disease, etc.)
Number at birth of this mother including previous births 2
Is mother now living Yes

FATHER
Name John J. Smith
Residence (Usual place of abode) Chicago, Ill.
If nonresident give place and State
Color or race White
Age at last birthday 34
Birthplace Chicago, Ill.
MOTHER
Name Anna M. Smith
Residence (Usual place of abode) Chicago, Ill.
If nonresident give place and State
Color or race White
Age at last birthday 28
Birthplace Chicago, Ill.

CERTIFICATE OF ATTENDING PHYSICIAN
I hereby certify that I attended the birth of this child, who was born at Chicago, Ill. on the date above stated.
(Signature) Dr. J. H. Smith

Where there was no attending physician or midwife, then the father, mother, or other person who should make this return, if a physician or midwife, should make this return. If a physician or midwife, should make this return. If a physician or midwife, should make this return.

FORM V. S. No. 5

RECEIVED MAY 10 1928

CERTIFICATE OF DEATH

61388

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho
City of CottonwoodRegistration District No. 105
Primary Registration District No. 2183
(No. _____ St.)File No. 6
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn Finley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant.
(Write the word.)

6. DATE OF BIRTH

4-17-1928
(Month) (Day) (Year)

7. AGE

StillbornIF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF FATHER

R. H. Finley

11. BIRTHPLACE OF FATHER

(State or Country) Tennessee.

12. MAIDEN NAME OF MOTHER

Louise Pearson

13. BIRTHPLACE OF MOTHER

(State or Country) Nash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. R. H. Finley
(Address) Cottonwood, Id.

15.

Filed 4-18 1928

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4-17-1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 19____, to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:Stillborn

_____ (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. A. Woodcock M. D.4-18-1928 (Address) Cottonwood, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Cottonwood

DATE OF BURIAL

4-18-1928

20. UNDERTAKER

W. J. O'Connell

ADDRESS

Cottonwood

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Jerome
City of Jerome

No. 683-210-027-342 St.

(If born in hospital or institution
give name.)

RECEIVED MAY 11 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 18 State File No. 161041

Prim. Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child ♂

Twin
Triplet
or other? 1
(To be answered only in event of plural births)

and { Number
in order
of birth
4

Legiti-
mate? yes

Date of
birth Feb 10

(Month)

(Day)

1928
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 4 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Hartford J. Goff

MOTHER
FULL MAIDEN NAME Rozel E. Goshman

Residence (Usual place of abode) Jerome

Residence (Usual place of abode) Jerome

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race White Age at last Birthday 40

Color or race White Age at last Birthday 39

Birthplace Kansas
(City and State or Country)

Birthplace Kansas
(City and State or Country)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 1:30 P. M.
on the date above stated.

(Signature) Dr. C. F. Zeller

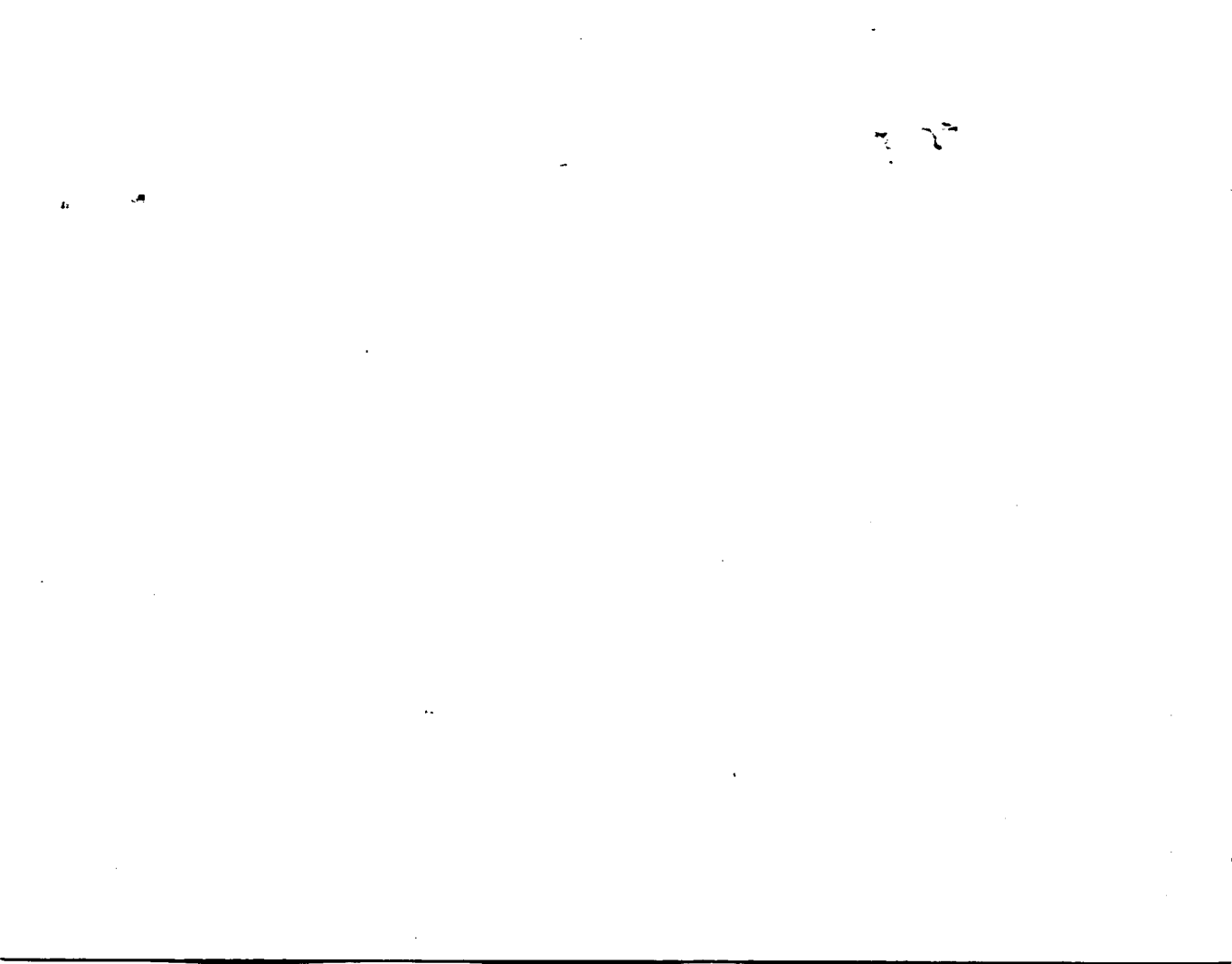
(Physician or midwife)

Address Jerome Idaho

Filed 19 Dr. C. F. Zeller

Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of JeromeCity of Jerome

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St.)

File No. 30979

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unmanned Hyckhoff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Write the word6. DATE OF BIRTH Feb 10 1928
(Month) (Day) (Year)7. AGE X Yrs. X Mos. X ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Jerome Idaho10. NAME OF FATHER Walter H. Hyckhoff

11. BIRTHPLACE OF FATHER

(State or Country) Kansas12. MAIDEN NAME OF MOTHER Agnes L. Bushman

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Hyckhoff(Address) Jerome, Idaho15. Filed 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 10 1928
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 19 to 19that I last saw him alive on 19and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born infant
Cystic Placental Degeneration

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. F. Zeller M. D.19 (Address) Jerome, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Jerome Cemetery Feb 10 1928

20. UNDERTAKER ADDRESS

D. R. L. Harrison Jerome

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *-Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

395-119-228-231
PLACE OF BIRTH RECEIVED APR 16 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

County of Noten
City of Grand View
No. 72 3rd St.

Registration District No. 30 State File No. S 61088

(If born in hospital or institution give name.)

Prim. Registration District No. 151 Local Registrar's No. 46

FULL NAME OF CHILD Steborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <u>4/2</u>	Date of birth <u>Feb 19 1928</u> (Month) (Day) (Year)
-----------------------	---	-----	--------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 1 (a) Born alive and now living None

Born alive but now dead None Stillborn Yes

FATHER
FULL NAME Theodore A. Jensen

MOTHER
FULL MAIDEN NAME Catherine Elizabeth Scanlon

Residence (Usual place of abode) Corr d'Alene Idaho

Residence (Usual place of abode) Corr d'Alene, Idaho

If nonresident, give place and State

If nonresident, give place and State

Color or race White Age at last Birthday 31
(Years)

Color or race White Age at last Birthday 30
(Years)

Birthplace Illinois
(City and State or Country)

Birthplace Washington
(City and State or Country)

Occupation Mechanic

Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at Corr d'Alene Idaho M. on the date above stated.

(Signature) [Signature]

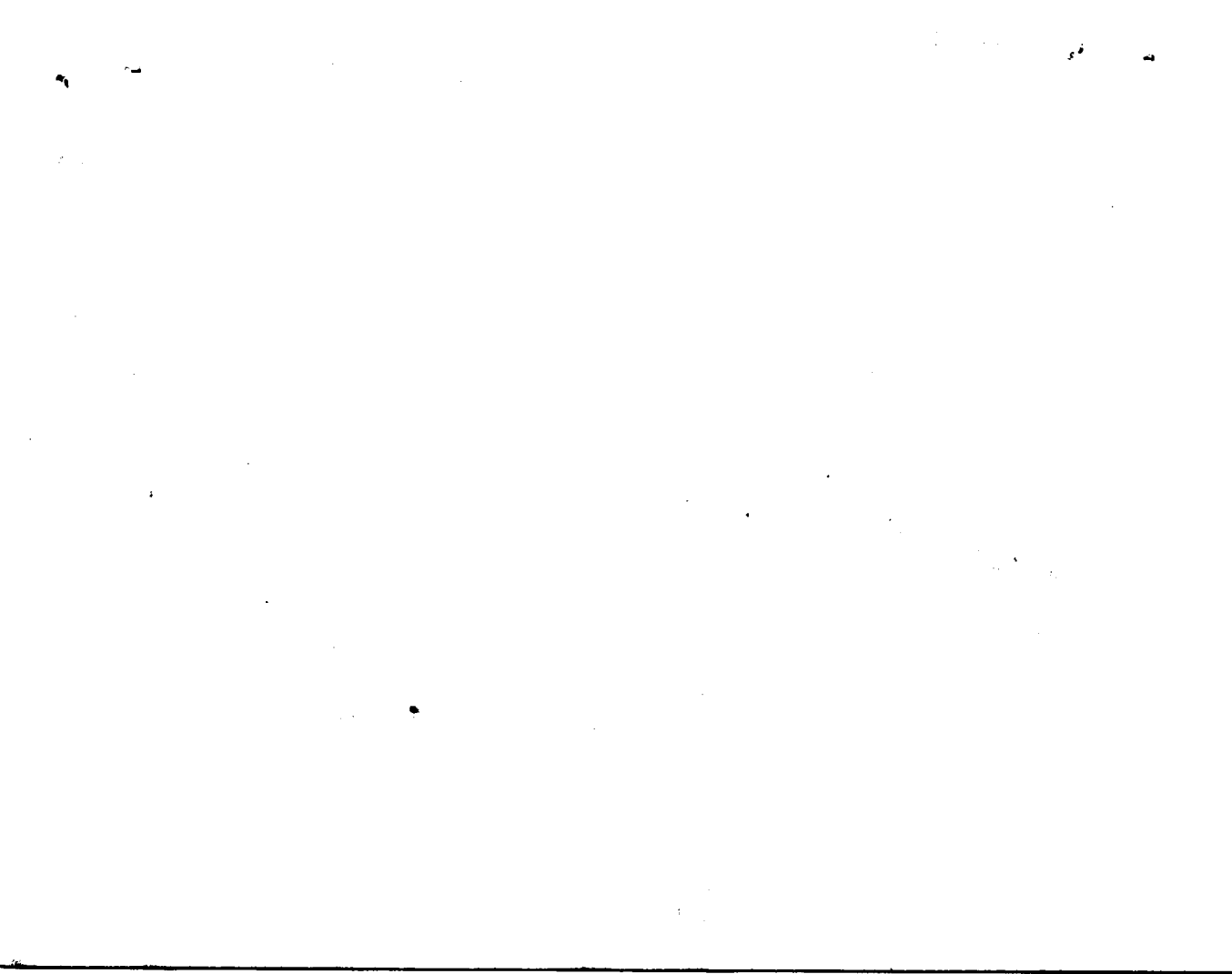
(Physician or midwife)

Address Corr d'Alene Idaho

Filed 4/5 1928 D. W. Drennon

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 9 1928

PLACE OF DEATH

County of Coconino
City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 30
Primary Registration District No. 105-1

DO NOT WRITE IN THIS SPACE

State File No. 60653Local Registrar's No. 30

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. Lawrence Ticken 320-816 St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1928 2-19

7. AGE Years Months Days If LESS than 1 day,
0 0 0 0 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work d

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene Ida
(State or country)

10. NAME OF FATHER Theodore Ticken

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER Catherine Scoular

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Hopewell W

14. Informant Mrs. T. Ticken
(Address)

15. Filed 2/29, 1928 D. D. Brennan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 19 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19.....

that I last saw h..... alive on....., 19.....

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Still born infant. (Anemia - Pernicious)
Scleremia

(duration)yrs.mos.ds.

CONTRIBUTORY

(Secondary)

(duration)yrs.mos.ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

1 (Signed) J. D. Brennan M. D.
Feb 20, 1928 (Address) Coeur d'Alene, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Forest Cem. Coeur d'Alene

2-20 1928

20. Undertaker

Address

Cassidy Funeral Home

Coeur d'Alene

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

666-264- RECEIVED APR 16 1928
PLACE OF BIRTH
028-369 Kootenai
County of
City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. _____ St. _____

Home Hospital

(If born in hospital or institution
give name.)

Registration District No. 30 State File No. 161090

Prim. Registration District No. 105-1 Local Registrar's No. 48

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child female	Twin Triplet or other? <input type="checkbox"/>	and { Number in order of birth 2 }	Legiti-mate? Yes	Date of birth 3 4 1928 (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? *AgNO₃ 1%*

Number of child of this mother, including present birth 2 (a) Born alive and now living

Born alive but now dead _____ Stillborn 2

FATHER
FULL NAME Warren W. Wood
Residence (Usual place of abode) Coeur d'Alene

If nonresident, give place and State _____

Color or race white Age at last Birthday 25
(Years)

Birthplace Bozeman, Montana
(City and State or Country)

Occupation Laborer

MOTHER
FULL MAIDEN NAME Edna Cordner
Residence (Usual place of abode) Coeur d'Alene

If nonresident, give place and State _____

Color or race white Age at last Birthday 20
(Years)

Birthplace VanConver, B. C.
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { ~~born alive~~ Stillborn at 12 A. M.
on the date above stated.

(Signature)

Harold J. Sturges MD
Physician
(Physician or midwife)

Address Coeur d'Alene, Idaho

Filed 4/5- 1928 D. O. Brennan
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1

2

3

4

5

6

7

RECEIVED APR 16 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **61398**Local Registrar's No. **44**

PLACE OF DEATH

County of MontanaCity of CamdenRegistration District No. 30Primary Registration District No. 1051(No. Same Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Baby Wood

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) Mar 4 1928

7 AGE

Years

Months

Days

1 If LESS than
day, 0 hrs.
or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Camden Idaho

10 NAME OF FATHER

Harvey H. Wood11 BIRTHPLACE OF FATHER (city or town)
(State or country)Montana

12 MAIDEN NAME OF MOTHER

Edna Porden13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Canada

14

Informant

(Address)

Harvey H. Wood811 Boyd Ave.
Camden Idaho

15

Filed

Mar. 13, 1928D. D. Drinnan

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar.
(Month)4
(Day)1928
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 4, 1928, to Mar. 4, 1928that I last saw him alive, 1928

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Still born - Due to eclampsia
condition of mother.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Harold J. Sturge, M. D.
Mar 5, 1928 (Address) Camden Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Forest Cemetery3/5 1928

20. Undertaker

Address

R. B. Morney Camden Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED APR 16 1928

PLACE OF BIRTH

STATE OF IDAHO

County of Kootenai

DEPARTMENT OF PUBLIC WELFARE

City of Coeur d'Alene

BUREAU OF VITAL STATISTICS

No. 5 St.

CERTIFICATE OF BIRTH

S 161092

255207028-345

Registration District No. 20 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 1257 Local Registrar's No. 50

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>(To be answered only in event of plural births)</u>	and { Number in order of birth <u>3</u> }	Legiti- mate? <u>yes</u>	Date of birth <u>3</u> <u>7</u> <u>1928</u> (Month) (Day) (Year)
----------------------------	---	---	--------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 1 Stillborn 1

FATHER

FULL NAME Elmer C. Benson

Residence (Usual place of abode) Coeur d'Alene

If nonresident, give place and State

Color or race white Age at last Birthday 32

Birthplace Spokane, Washington (Years)

(City and State or Country)
Occupation Farmer

MOTHER

FULL MAIDEN NAME Kathar Lundeen

Residence (Usual place of abode) Coeur d'Alene

If nonresident, give place and State

Color or race white Age at last Birthday 25

Birthplace Coeur d'Alene, Idaho (Years)

(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at 1 A. M.

(Signature) Harold J. Sturgeon MD

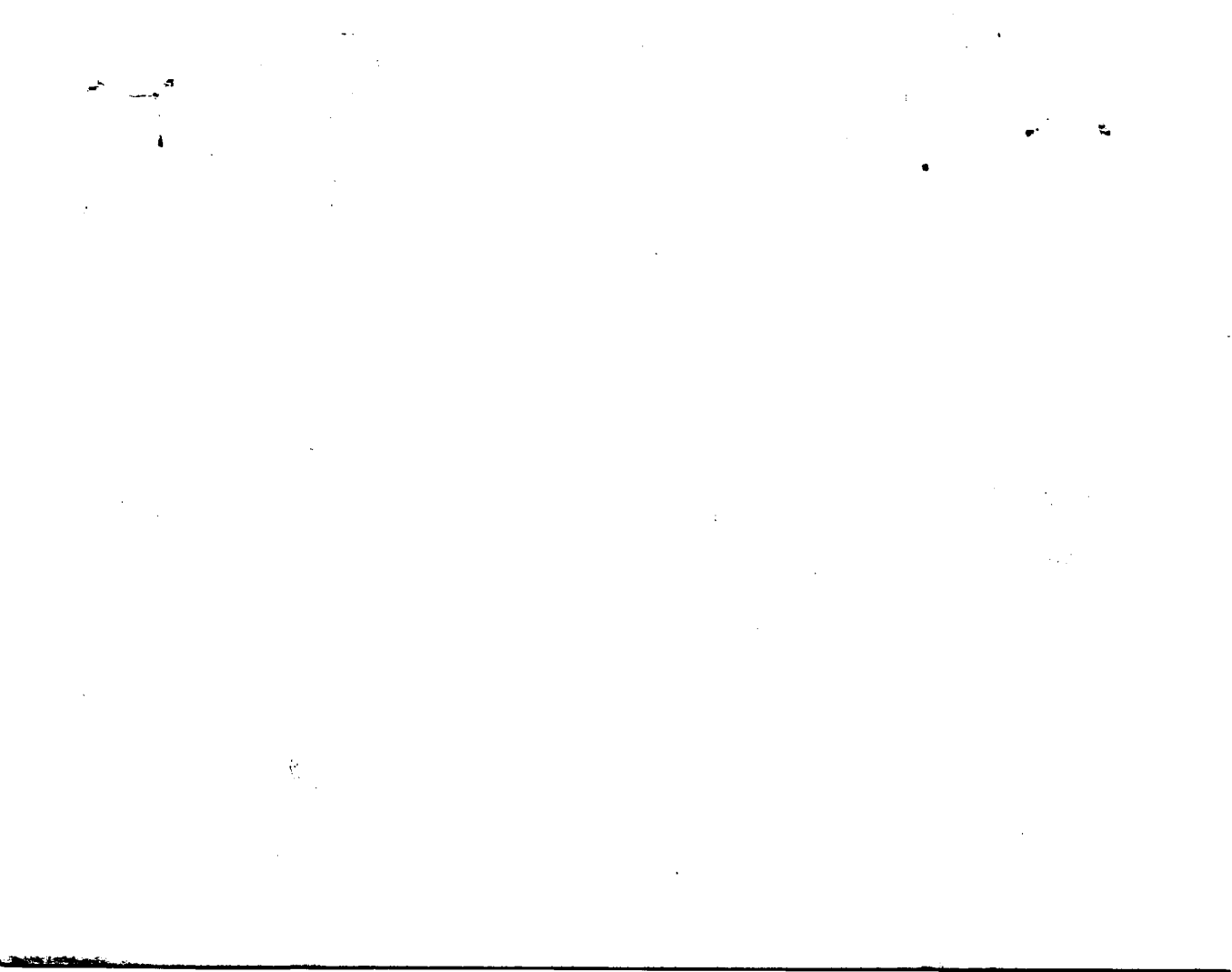
Physician
(Physician or midwife)

Address Coeur d'Alene, Idaho

Filed 4/5 1928 D. O. Brennan

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED APR 16 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **61399**

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1057

Local Registrar's No. 45

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)
2. FULL NAME Mora Benson
(a) Residence. No. 1026 - 2nd St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX F. 4. COLOR OR RACE W. 5. Single, Married, Widowed, or Divorced (write the word) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6. DATE OF BIRTH (month, day and year) 1925-3-7
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Coeur d'Alene, Idaho
(State or country)
10. NAME OF FATHER Elmer Benson
11. BIRTHPLACE OF FATHER (city or town) Spokane
(State or Country) W.
12. MAIDEN NAME OF MOTHER Ester Lundeen
13. BIRTHPLACE OF MOTHER (city or town) Sweden
(State or Country)

14. Informant Elmer Benson
(Address)

15. Filed 3/16, 1928 DD Benson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 7, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 7, 1928, to Mar 7, 1928
that I last saw her alive on Mar 7, 1928
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Primitivesstillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? No Date of _____
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Harold J. Sturges, M. D.
Mar. 10, 1928 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Exposure Forest Home Cemetery, Coeur d'Alene Date of Burial 3-8, 1928
Cassedy Funeral Home

20. Undertaker Cassedy Funeral Home Address Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

257-218,029-238
PLACE OF BIRTH

County of Idaho
City of Potlatch
No. _____ St. _____

RECEIVED APR 21 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 65 State File No. 161134

(If born in hospital or institution
give name.)

Prim. Registration District No. 2145 Local Registrar's No. _____

FULL NAME OF CHILD Maya (Beaman) Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	<input checked="" type="checkbox"/> Twin <input checked="" type="checkbox"/> Triplet <input type="checkbox"/> or other?	and <input checked="" type="checkbox"/> Number in order of birth <u>2nd</u>	Legitimate? <u>yes</u>	Date of birth <u>March 18</u> 19 <u>28</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 7 (a) Born alive and now living 6

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Charles Beaman
Residence (Usual place of abode) Potlatch
If nonresident, give place and State ✓
Color or race white Age at last Birthday 32
Birthplace Gaylord - Kansas
(City and State or Country)
Occupation Lumber

MOTHER
FULL MAIDEN NAME Stella Schell
Residence (Usual place of abode) Idaho
If nonresident, give place and State ✓
Color or race white Age at last Birthday 30
Birthplace Nebraska
(City and State or Country)
Occupation Housewife

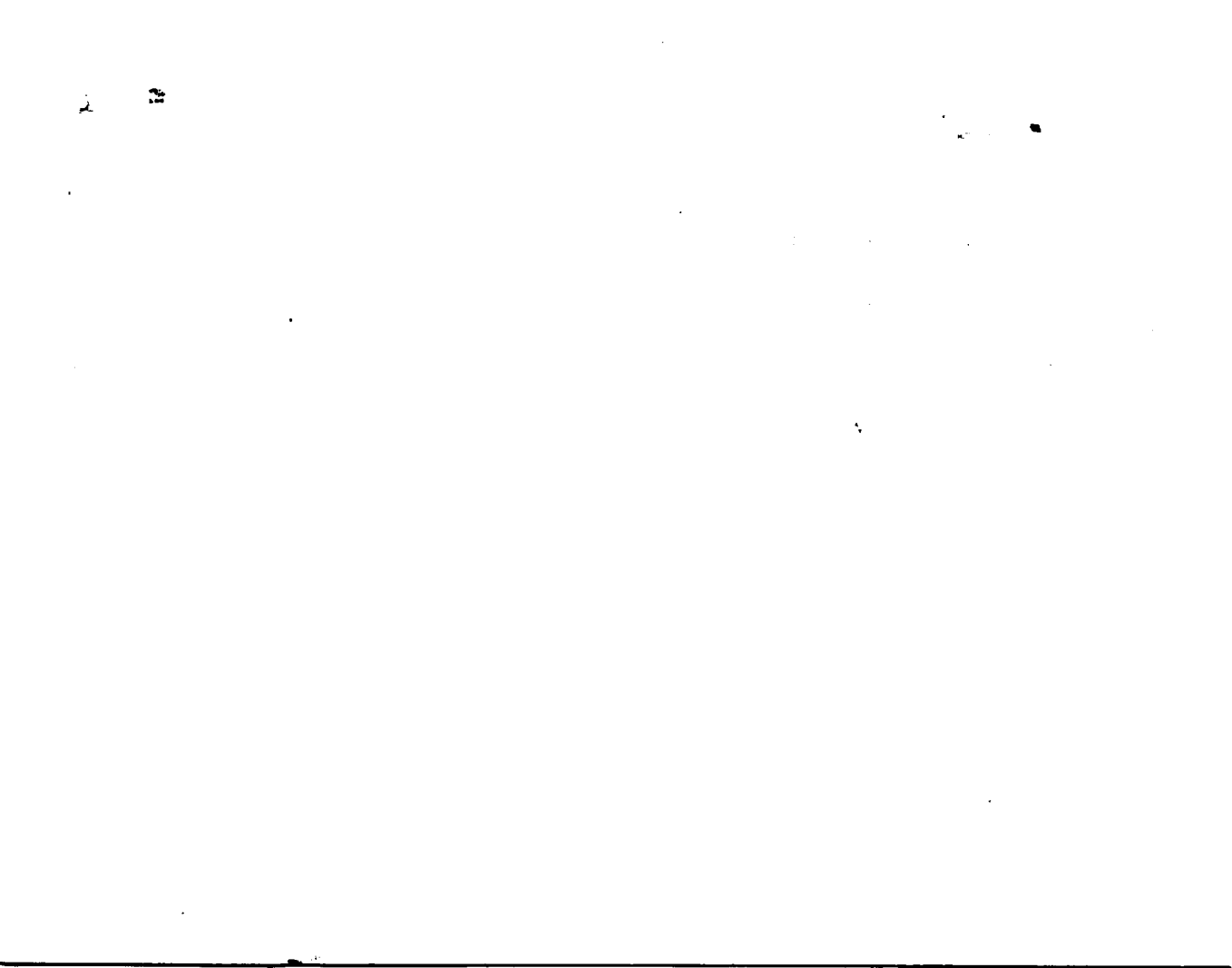
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 11:15 M.
on the date above stated.

(Signature) D. W. Thompson
m. d.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Potlatch
Filed March 24 1928 D. W. Thompson
Registrar.



RECEIVED APR 21 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **51429**

PLACE OF DEATH

County of LatahCity of PrincetonRegistration District No. 65Primary Registration District No. 2145

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. Princeton St. _____(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
-------------------------	----------------------------------	--

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓6. DATE OF BIRTH (month, day and year) March 18

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) ✓(c) Name of employer ✓9. BIRTHPLACE (city or town) Boothville
(State or country)10. NAME OF FATHER Charles Beaman11. BIRTHPLACE OF FATHER (city or town) England
(State or Country) Kansas12. MAIDEN NAME OF MOTHER Stella Schell13. BIRTHPLACE OF MOTHER (city or town) Nelruska
(State or Country)14. Informant Charles Beaman
(Address) Princeton15. Filed March 20th 1928 D. J. Thompson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 18 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

✓, 19 , to ✓, 19 that I last saw h alive on ✓, 19 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

still born

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Premature birth
(duration) yrs. mos. ds.18. Where was disease contracted
if not at place of death? ✓Did an operation precede death? ✓ Date of Was there an autopsy? ✓What test confirmed diagnosis? (Signed) a. J. W. Thompson M. D.March 20th 1928 (Address) Boothville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

SoonMarch 20 1928

20. Undertaker

Address

ParentsBoothville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

STATE OF OHIO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Record Number

DATE OF BIRTH

PLACE OF BIRTH

TA
YAD

DATE OF BIRTH

Year

RECEIVED
JAN 11 1904
BUREAU OF VITAL STATISTICS
STATE OF OHIO

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 9 1928

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lemhi
City of Lemhi

Registration District No. 42

Primary Registration District No. 2153

(No.), (St.)

File No. 61439

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Ling

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

April 12 1928
(Month) (Day) (Year)

7. AGE

Stillborn

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Lemhi Idaho

10. NAME OF FATHER

Kernal Ling

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary Martin

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Kernal Ling

(Address)

Lemhi, Idaho

15.

Filed

5/7 1928

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 12 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/12 1928 to 4/12 1928

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn about ten days intramutering death. Cause unknown
(Duration) Yrs. mos. ds.Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

John T. Bubbis M. D.

5/7 1928 (Address) Leadore, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lemhi

4/13 1928

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name or *gin*; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

156-130-033-155
PLACE OF BIRTH
County of Nebraska
City of Rehburg
No. St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
MAY 10 1928
CERTIFICATE OF BIRTH

S 161181

Registration District No. 100 State File No.
Prim. Registration District No. 2178 Local Registrar's No. 80

(If born in hospital or institution
give name.)

FULL NAME OF CHILD
(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>April 30</u> (Month) (Day) (Year) <u>1928</u>
--------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 0 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Melvin P. Jeffs

Residence (Usual place of abode) Rehburg

If nonresident, give place and State

Color or race W Age at last Birthday 24
(Years)

Birthplace Idaho
(City and State or Country)

Occupation Western Automobile

MOTHER
FULL MAIDEN NAME Thelma Jensen

Residence (Usual place of abode) Rehburg

If nonresident, give place and State

Color or race W Age at last Birthday 20
(Years)

Birthplace Wyo
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Delivered Stillborn M.
on the date above stated.

(Signature) H. B. Rigby, M.D.

(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address

Filed 5/1 1928 J. P. Young
J. B. Echorn
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED MAY 10 1928
PLACE OF DEATH
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 61448

County of MadisonRegistration District No. 100City of ReynoldsburgPrimary Registration District No. 2-178Local Registrar's No. 43

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Jeffs(a) Residence, No. 7 Reynoldsburg St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofInfant6 DATE OF BIRTH (month, day and year) April 23 19287 AGE Years Months Days 2 If LESS than day, hrs. min. Stillborn

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Reynoldsburg Idaho
(State or country)10 NAME OF FATHER Malvin Jeffs11 BIRTHPLACE OF FATHER (city or town)
(State or country) Idaho12 MAIDEN NAME OF MOTHER Thelma Jensen13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Idaho14 Informant Malvin Jeffs
(Address)15 Filed 5/3 19 28 Registrar John E. Edwards

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 30 19 28
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from April 30 19 28, to April 30 19 28, that I last saw him alive on April 30 19 28, and that death occurred, on the date stated above, at Reynoldsburg m.

The CAUSE OF DEATH* was as follows

Stillborn
Had been dead about 12 hrs
before delivery. Cause unknown
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. B. Bigby M. D.
May 1 19 28 (Address) Reynoldsburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Reynoldsburg May 1 19 2820. Undertaker W. B. Bigby Address Reynoldsburg

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of uterine gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of MinidokaCity of Reupert

No. _____ St. _____

395 224-034-824(If born in hospital or institution
give name.)Registration District No. 19 State File No. _____Prim. Registration District No. 2015 Local Registrar's No. 65FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>7</u>	Twin Triplet or other? (To be answered only in event of plural births)	(Number and in order of birth)	Legitimate? <u>1/8</u>	Date of birth <u>4 28 1928</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? Silver Nitrate Sol. 1%Number of child of this mother, including present birth 4 (a) Born alive and now living 3Born alive but now dead 1 Stillborn _____

FATHER FULL NAME <u>Reupert Clyde Lindsey</u>	MOTHER FULL MAIDEN NAME <u>Jina Hymas</u>
--	--

Residence (Usual place of abode) Reupert Idaho

If nonresident, give place and State _____

Color or race W Age at last Birthday 40 (Years)Birthplace Idaho (City and State or Country)Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at 6²⁷ A. M.(Signature) Delmar Tragni

(Physician or midwife)

Address Reupert, IdahoFiled 5-7 1928 W. E. Hume

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

1928-192640

DwPOB 1928-192640

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

242-202-036-165
PLACE OF BIRTH
RECEIVED MAY 7 1928
STATE OF IDAHO.
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Carroll
CITY OF Malad
No. _____ St. _____ Registration District No. 26 State File No. 161277
Hospital _____ Primary Registration District No. 2069 Local Registrar's No. 56
FULL NAME OF CHILD _____
(Certificate of no value without full name of child)
Sex of Child Female Twin Triplet or other? _____ } and { Number in order of birth _____ Legitimate? Yes Date of birth 4-2 1928
(To be answered only in event of plural births) (Month) (Day) (Year)
What bactericidal solution was used in eyes? Agro 3
Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2
FULL NAME FATHER Warren Bush FULL MAIDEN NAME MOTHER Mary B. Jones
RESIDENCE Malad Ida RESIDENCE Malad Ida
COLOR White AGE AT LAST BIRTHDAY 27 COLOR White AGE AT LAST BIRTHDAY 23
(Years) (Years)
BIRTHPLACE Malad Ida BIRTHPLACE Malad Ida
OCCUPATION Furnace OCCUPATION Housewife
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*
I hereby certify that I attended the birth of this child, who was Stillborn at 10:30 a.m.
on the date above stated.
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report. _____, 1928

Registrar. Address _____
Filed 4/30 1928 _____
Registrar.

NO D

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

864-210-037-449
PLACE OF BIRTH

RECEIVED MAY 1 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S
161299

CERTIFICATE OF BIRTH

County of Owyhee

City of Grand View

No. _____ St. _____ Registration District No. 74 State File No. _____

Hospital _____ Primary Registration District No. 2151 Local Registrar's No. 121

FULL NAME OF CHILD Jane Doe Young

(Certificate of no value without full name of child)

Sex of Child <u>7</u>	Twin Triplet or other? <u> }</u> and <u> {</u> Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>April 10</u> <u>1928</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Herbert John Young
RESIDENCE Grand View
COLOR White AGE AT LAST BIRTHDAY 40
(Years)
BIRTHPLACE North Dakota
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Ellen May Murphy
RESIDENCE Grand View
COLOR White AGE AT LAST BIRTHDAY 36
(Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 1:15 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. _____, 1928

(Signature) W. J. Eidenbach

Physician
(Physician or midwife)

Address Grand View

Filed May 1 1928 W. J. Eidenbach

Registrar.

THIS IS A CERTIFICATE OF BIRTH FOR THE CHILD OF THE NAME OF THE CHILD AS SHOWN IN THE RECORDS OF THE BUREAU OF VITAL RECORDS OF THE STATE OF NEW YORK. THE CHILD WAS BORN ON THE DATE AND AT THE PLACE SHOWN IN THE RECORDS OF THE BUREAU OF VITAL RECORDS OF THE STATE OF NEW YORK. THE CHILD WAS BORN TO THE MOTHER AND FATHER SHOWN IN THE RECORDS OF THE BUREAU OF VITAL RECORDS OF THE STATE OF NEW YORK. THE CHILD WAS BORN TO THE MOTHER AND FATHER SHOWN IN THE RECORDS OF THE BUREAU OF VITAL RECORDS OF THE STATE OF NEW YORK.

STATE OF NEW YORK
BUREAU OF VITAL RECORDS
COUNTY OF [REDACTED]

CERTIFICATE OF BIRTH

No. [REDACTED] State File No. [REDACTED]
Primary Registration Number [REDACTED] Local Registrar's No. [REDACTED]

FULL NAME OF CHILD [REDACTED]
(Indicate if no name without full name of child)
Sex of Child [REDACTED]
Date of Birth [REDACTED] (Month) (Year)
Place of Birth [REDACTED] (City) (State) (Country)
What jurisdiction, addition was used in case? [REDACTED]

Number of child of [REDACTED] including present birth [REDACTED]
Number of child of [REDACTED] including present birth [REDACTED]
FATHER [REDACTED]
MOTHER [REDACTED]
NAME [REDACTED]

RESIDENCE [REDACTED]
COLOR [REDACTED]
AGE AT LAST BIRTHDAY [REDACTED]
BIRTHPLACE [REDACTED]
OCCUPATION [REDACTED]
CITY [REDACTED]
STATE [REDACTED]
COUNTRY [REDACTED]

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was [REDACTED] on the date above stated.

(Signature) [REDACTED]
Physician or midwife
Address [REDACTED]
City [REDACTED]
State [REDACTED]
Country [REDACTED]

When there was no attending physician or midwife, the father, grandfather, etc. should make this report. A stillborn child is one that neither breathes nor shows other evidence of life after birth. (The names added from a supplemental report)

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED MAY 18 1928

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 161499

County of Sanrock
City of Pocatello
No. 693-210-003-291 St.

Registration District No. 28 State File No. 161499

(If born in hospital or institution give name.)

Prim. Registration District No. 261 Local Registrar's No. 8667

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twins Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>4-10-28</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1
Born alive but now dead 0 Stillborn 1

FATHER FULL NAME Carl R. Willard FULL MAIDEN NAME Marie Brandt

Residence (Usual place of abode) Pocatello Residence (Usual place of abode) Pocatello

If nonresident, give place and State

Color or race W Age at last Birthday 33 Color or race W Age at last Birthday 31
(Years) (Years)

Birthplace Kansas Birthplace Pocatello
(City and State or Country) (City and State or Country)

Occupation Truck Driver Occupation Physician

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

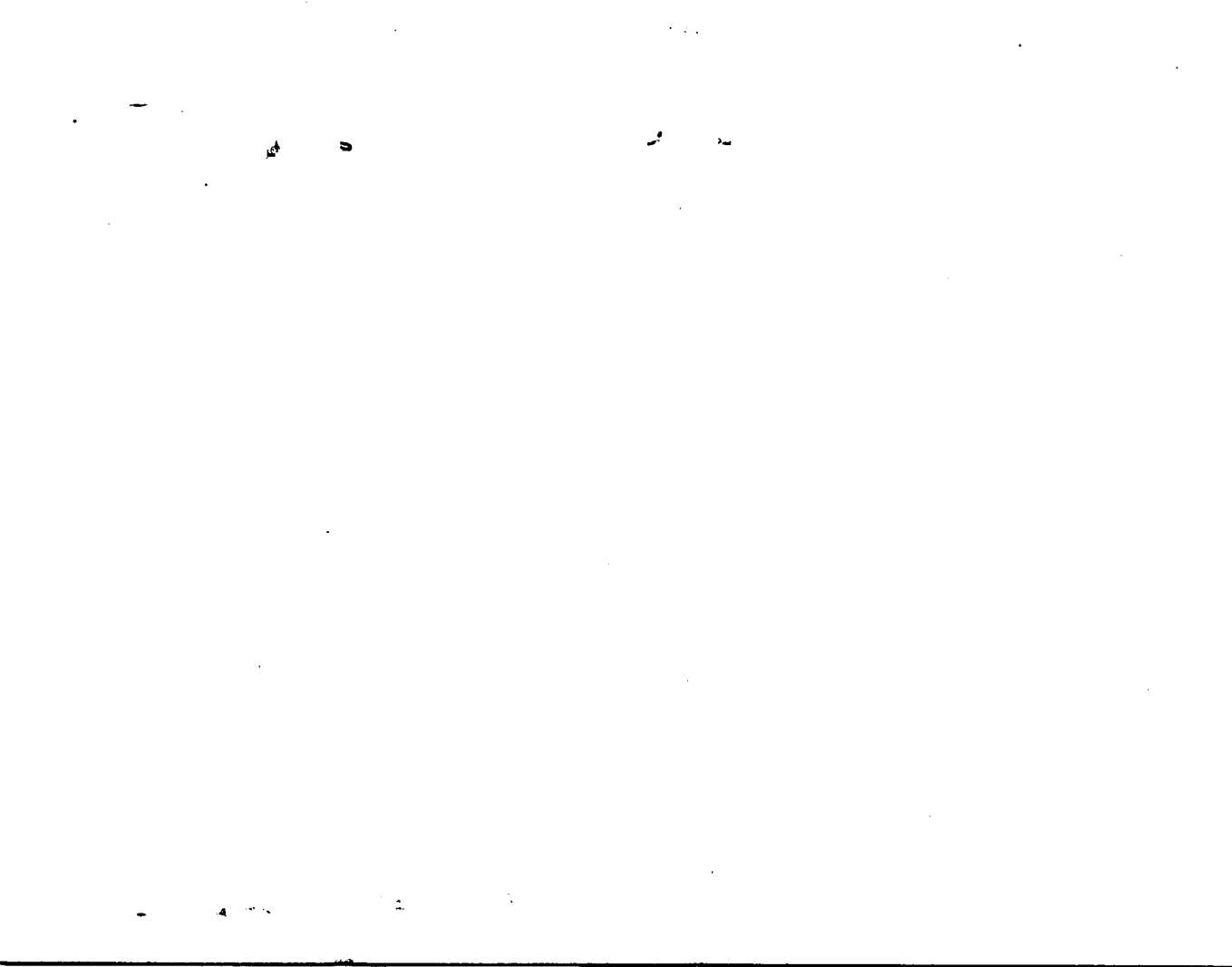
I hereby certify that I attended the birth of this child, who was Stillborn at 10 M.
on the date above stated.

(Signature) Dr. J. R. ...

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Pocatello

Filed 7/1 1928 J. R. ... Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 18 1928

PLACE OF DEATH

County of

City of

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No.

(No. _____) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 61620

Local Registrar's No. 5758

2. FULL NAME

(a) Residence No.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant (Address)

15. Filed

4/12, 1928

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

4/11, 1928

(Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

319-222-003-154

PLACE OF BIRTH RECEIVED MAY 18 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Bainbridge
City of McCannon
No. _____ St. _____

CERTIFICATE OF BIRTH

S161523

Registration District No. 27 State File No. _____

Prim. Registration District No. 3121 Local Registrar's No. 7222

(If born in hospital or institution
give name.)

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>April 22 1928</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 10 (a) Born alive and now living 8

Born alive but now dead none Stillborn 2

FATHER
FULL NAME L. L. Larsen

MOTHER
FULL MAIDEN NAME Birdella Anderson

Residence (Usual place of abode) McCannon, Ida.

Residence (Usual place of abode) McCannon, Ida.

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race White Age at last Birthday 39
(Years)

Color or race White Age at last Birthday 37
(Years)

Birthplace Fairview Utah
(City and State or Country)

Birthplace Manana Colo
(City and State or Country)

Occupation _____

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 9 20 A. M.
on the date above stated.

(Signature) H. F. Schwaninger M.D.

(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address Lawrence, Idaho

Filed 27 1928 Registrar

WE HAVE
RECEIVED

CERTIFICATE OF BIRTH

Registration District No. _____

Registration District No. _____

DATE OF BIRTH _____

Child's name at birth _____

Sex _____
Date of birth _____
Place of birth _____
Name of mother _____
Name of father _____

Child proposed and born to _____

Child proposed and born to _____

Child proposed and born to _____

NAME
MILAN
FULL
NAME

NAME
MILAN
FULL
NAME

Residence (last place of abode) _____

Residence (last place of abode) _____

It is hereby certified that _____

It is hereby certified that _____

Color or race _____

Color or race _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

CERTIFICATE OF BIRTH

I hereby certify that I attended the birth of this child, who was _____

(Signature)

I hereby certify that I attended the birth of this child, who was _____

Address _____

Signature _____

FORM V. S. No. **RECEIVED MAY 18 1928**

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 24

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 61639

Registered No. 5277

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

(Write the word.)

6. DATE OF BIRTH

April 22 28
(Month) (Day) (Year)

7. AGE

Still

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

McCannon, Idaho

10. NAME OF FATHER

L. L. Larson

11. BIRTHPLACE OF FATHER

(State or Country)

Fairview, Utah

12. MAIDEN NAME OF MOTHER

Birdella Anderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Manana, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. L. Larson

(Address)

McCannon, Idaho

15.

Filed

5/1 28

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 22 28
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Seven months gestation

(Duration) yrs. mos. ds.
Contributory (Secondary) Poor health & nephritis of mother(Duration) yrs. mos. ds.
(Signed) D. J. Hartwigson M. D.

(Address) Downey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

McCannon, Idaho

DATE OF BURIAL

4-24-1928

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

134-124-003 381

PLACE OF RECEIVED MAY 18 1928

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

County of Bannock.
Pocatello.

City of _____
No. 357 No. 4th. Ave. St.

Registration District No. 28

File No. 161524

Hospital _____

Primary Registration District No. 1

Registered No. 2212

FULL NAME OF CHILD Henry Aldrich.

Sex of Child <u>Male.</u>	<u>Twins</u> Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <u>Yes.</u>	Date of Birth <u>Apr. 24. 38.</u> (Month) (Day) (Year)
---------------------------	---	-----	--------------------------------	-------------------------	---

FATHER
FULL NAME William Aldrich.

MOTHER
FULL MAIDEN NAME Rosy Chambers.

RESIDENCE
357 No. 4th. Ave.

RESIDENCE
357 No. 4th. Ave.

COLOR Colored. AGE AT LAST BIRTHDAY 39
(Years)

COLOR Colored. AGE AT LAST BIRTHDAY 34
(Years)

BIRTHPLACE
Colorado.

BIRTHPLACE
Idaho.

OCCUPATION Painter helper
WHAT BAC. CIRCULAR SOLUTION WAS USED IN EYES?

OCCUPATION AGNO. #. 1.

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn. at 9. P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Loomis
Phy.

(Physician or midwife)

Given names added from a supplemental report.

140 No. Johnson.

Address

Filed

Registrar

Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 18 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 61637

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28

Primary Registration District No. 241

Local Registrar's No. 5275

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henny Aldrich

(a) Residence. No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Colored 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 24, 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still born.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello, Ida
(State or country)

10. NAME OF FATHER William Aldrich

11. BIRTHPLACE OF FATHER (city or town) Louisiana
(State or Country)

12. MAIDEN NAME OF MOTHER Rose Chambers

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Wm. Aldrich
(Address) Pocatello Idaho

15. Filed Apr. 25, 1928 Wm. Aldrich
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 24, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24, 1928 to April 24, 1928
that I last saw him alive on April 24, 1928
and that death occurred, on the date stated above, at 9:30 P. M.
The CAUSE OF DEATH was as follows:
still born

CONTRIBUTORY still born
(Secondary)

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?
(Signed) W. L. Jones, M. D.
April 25, 1928 (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal Pocatello, Ida Date of Burial April 25, 1928

20. Undertaker McKee and Co. Address Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

415.101.003.415

PLACE OF BIRTH

County of Boone
City of Pocatello
No. St. Anthony St.

RECEIVED JUN 16 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

161554

Registration District No. 1 State File No. 161554

Prim. Registration District No. 2 Local Registrar's No. 223

FULL NAME OF CHILD William Henry Davis
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>4 - 1 - 1928</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 1

Born alive but now dead None Stillborn 1

FATHER
FULL NAME Thomas Davis

MOTHER
FULL MAIDEN NAME Hazel Davis

Residence (Usual place of abode) American Falls, Idaho

Residence (Usual place of abode) American Falls, Idaho

If nonresident, give place and State

If nonresident, give place and State

Color or race W Age at last Birthday 28 (Years)

Color or race W Age at last Birthday 34 (Years)

Birthplace Colorado Springs, Colo
(City and State or Country)

Birthplace Moulton, Iowa
(City and State or Country)

Occupation Merchant

Occupation Mail

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive
on the date above stated. Stillborn } at 145 P. M.

(Signature) W. B. Broderick

{ *Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

(Physician or midwife)

Address Pocatello

Filed ap. 1928 Registrar.

NEED TO STAY INSIDE

SECRET

1941-1942

1964-1965

100-443887-100

(SECRET)

SECRET

100-443887-100

FROM 1074

SECRET

(b) (7)(D), (b) (7)(F)

attest my hand and seal this 1st day of May 1964

100-443887-100

10/10/69

1992-1993

10. () 11. () 12. () 13. () 14. () 15. () 16. () 17. () 18. () 19. () 20. ()

(continued)

19

10-10-22-07

100

newly established on new areas. The latter, however, are not as numerous as the former. The latter are more numerous in the areas of the former.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 18 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **61619**

PLACE OF DEATH

County of BernhamCity of PocatelloRegistration District No. 18Primary Registration District No. 2161(No. Poc Sen Hosp)
(If death occurred in a hospital or institution, give its name instead of street and number.)Local Registrar's No. 5250

2. FULL NAME

Infant David (David)(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white5. Single, Married, Widowed,
or Divorced (write the word)Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of worknone(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)Pocatello Ida

10. NAME OF FATHER

Thomas H. Davis11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Colorado

12. MAIDEN NAME OF MOTHER

Hazel Davison13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Idaho

14. Informant

(Address)

Thomas H. Davis
American 4141 S. 1st St

15. Filed

Apr 2, 1928

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 1, 1928
(Month) (Day) (Year)

17. HEREBY CERTIFY, That I attended deceased from

April 1, 1928, to April 1, 1928that I last saw him alive on April 1, 1928and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? No Date of Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

W. W. Crocker, M. D.4-2-28(Address) Pocatello*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Pocatello, Idaho Apr 2, 1928

20. Undertaker

Address

McHan and Co Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately, and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

814-131-2003-469
PLACE OF BIRTH
Bannock

County of _____
City of **Swan Lake**
No. _____ St.

(If born in hospital or institution
give name.)

Registration District No. **83** State File No. **161582**

Prim. Registration District No. **2160** Local Registrar's No. **391**

FULL NAME OF CHILD **Stillborn**

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? Yes	Date of birth May 31, 1928 (Month) (Day) (Year)
--------------------------	---	-----	--------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth **1** (a) Born alive and now living **0**

Born alive but now dead _____ Stillborn **1**

FATHER
FULL NAME **Rich Hadley**

Residence (Usual place of abode) **Swan Lake, Idaho**

If nonresident, give place and State _____

Color or race **White** Age at last Birthday **43**
(Years)

Birthplace **Idaho**
(City and State or Country)

Occupation **Farming**

MOTHER
FULL MAIDEN NAME **Ercil Morrison**

Residence (Usual place of abode) **Swan Lake, Idaho**

If nonresident, give place and State _____

Color or race **White** Age at last Birthday **40**
(Years)

Birthplace **Idaho**
(City and State or Country)

Occupation **Housewife**

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was **Stillborn** at **11:30 P.** M.
on the date above stated.

(Signature) **A. R. Butler**

Physician

(Physician or midwife)

Address **Preston, Idaho**

Filed **June 7-1928** **Lucy C. Coffey**
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

RECEIVED
JUL 10 1950
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

When there was an attempt to register or transfer from the Federal Government, etc. should make certain. A child born in the United States for shows of a certain kind.

Present, Idaho

Physician

(Signature)

I hereby certify that I attended the birth of this child, who was born on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN ON BIRTH

(Date and time of Birth)

Age of child (Years)

Sex

Place of birth (State, County, City, Town, etc.)

NAME OF CHILD

DATE OF BIRTH

PLACE OF BIRTH

NAME OF PHYSICIAN

DATE OF BIRTH

PLACE OF BIRTH

NAME OF CHILD

DATE OF BIRTH

PLACE OF BIRTH

NAME OF CHILD

DATE OF BIRTH

PLACE OF BIRTH

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 16 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 31677

County of Bannock
City of Swan Lake

Registration District No. 8
Primary Registration District No. 2160

Local Registrar's No. 89

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. _____ St. _____
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) May 31, 1928		
7. AGE 0	Years 0	Months 0
	Days 0	If LESS than 1 day, hrs. or min. 0
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. - (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) Swan Lake, Idaho
(State or country)

PARENTS	10. NAME OF FATHER Rich Hadley
	11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
	12. MAIDEN NAME OF MOTHER Ercil Morrison
	13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Rich Hadley
(Address) Swan Lake, Idaho

15. Filed June 11, 1928 Mary C. Coffin
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 31, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw h. _____ alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Died in the birth.
Purpion was necessary
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? _____
(Signed) J. R. Butler, M. D.
6-1, 19**28** (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker -	Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

Size of certificate, 6% x 7% inches.

V. & N. No. 110

MARGIN RESERVED FOR BINDING RECORD

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth, stated.

117-202- DEPARTMENT OF COMMERCE—BUREAU OF THE CENSUS State File No. 5
005-37600 STANDARD CERTIFICATE OF BIRTH Registered No. 31

1. PLACE OF BIRTH Renewal County Idaho State Idaho
Township Dr. Hunt or Village S
City _____ No. _____ St. _____ Ward _____
(If birth occurred in a hospital or institution, give its NAME instead of street and number)

2. Full name of child Unnamed Jamison (If child is not yet named, make supplemental report, as directed)

3. Sex of child M To be answered ONLY in event of plural births. 4. Twin, triplet or other _____ 5. Legitimate? Yes 6. Date of birth May 2-1928 (Month, day, year)

8. Full name of FATHER Peter Jamison 14. Full maiden name of MOTHER Rebecca Procham

9. Residence (Usual place of abode) Dr. Hunt Id. If nonresident, give place and State 15. Residence (Usual place of abode) Idaho If nonresident, give place and State

10. Color of race Indian 11. Age at last birthday 42 (Years) 16. Color of race Indian 17. Age at last birthday 36 (Years)

12. Birthplace (city or place) New York (State or country) 18. Birthplace (city or place) Mont (State or country)

13. Occupation Laborn Nature of Industry 19. Occupation H.W. Nature of Industry

20. Number of children of this mother (Taken as of time of birth of child herein certified and including this child.) 6 (a) Born alive and now living 5 (b) Born alive but now dead _____ (c) Stillborn 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*
I hereby certify that I attended the birth of this child, who was Stillborn at 3 1/2 m. on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Signature J. A. Neeson (Physician or Midwife)
Given name added from a supplemental report _____ Address Idaho
(Month, day, year) Filed May 3, 1928 John Post
Registrar. Registrar.

WHY BIRTHS SHOULD BE REGISTERED

There is hardly a relation of life, social, legal, or economic, in which the evidence furnished by an accurate registration of births may not prove to be of the greatest value, not only to the individual but also to the public at large. It is not only an act of civilization to register birth certificates but good business, for they are frequently used in many practical ways:

- (1) As evidence to prove the age and legitimacy of heirs;
- (2) As proof of age to determine the validity of a contract entered into by an alleged minor;
- (3) As evidence to establish age and proof of citizenship and descent in order to vote;
- (4) As evidence to establish the right of admission to the professions and to many public offices;
- (5) As evidence of legal age to marry;
- (6) As evidence to prove the claims of widows and orphans under the widows' and orphans' pension law;
- (7) As evidence to determine the liability of parents for the debts of a minor;
- (8) As evidence in the administration of estates, the settlement of insurance and pensions;
- (9) As evidence to prove the irresponsibility of children under legal age for crime and misdemeanor, and various other matters in the criminal code;
- (10) As evidence in the enforcement of law relating to education and to child labor;
- (11) As evidence to determine the relations of guardians and wards;
- (12) As proof of citizenship in order to obtain a passport;
- (13) As evidence in the claim for exemption from or the right to jury and military service.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 9 10 51 STANDARD CERTIFICATE OF DEATH

 DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

61720 Registered No. 5

1 PLACE OF DEATH

County

Benewah

State

Idaho

Township

or Village

Depue

City

Depue

No.

St.,

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

Unnamed Jamison

(a) Residence. No.

St.,

Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

 5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 2-1928

7 AGE

Years

Months

Days

 If LESS than
1 day, ____ hrs.
or ____ min.

Still born

8 OCCUPATION OF DECEASED

 (a) Trade, profession, or
particular kind of work

 (b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

 9 BIRTHPLACE (city or town)
(State or country)

Depue Idaho.

PARENTS

10 NAME OF FATHER

Peter Jamison

 11 BIRTHPLACE OF FATHER (city or town)
(State or country)

N. Y.

12 MAIDEN NAME OF MOTHER

Rebecca Bouchard

 13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Monh.

14

 Informant
(Address)

 Peter Jamison
Depue Idaho

15

Filed

May 3, 1928

John Post

REGISTRAR

11-3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

May 2-

19 28

17 I HEREBY CERTIFY, That I attended deceased from

May 2, 1928, to

19

that I last saw him alive on

19

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

 Still Born
transverse presentation
Podalic Version

 CONTRIBUTORY (duration) ____ yrs. ____ mos. ____ ds.
(SECONDARY) transverse presentation

 18 Where was disease contracted
if not at place of death?

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) J. A. Nelson, M. D.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Depue Idaho

May 3 1928

20 UNDERTAKER

 Dr. Louis Grossman
C. L. Schmitt

ADDRESS

Depue Idaho

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Coal engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (c) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Foreman*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer"; "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, coliculus, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

11-3184

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

459-215 010-575

PLACE OF RECEIVED MAY 16 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S
161747

County of Bonneville
City of Idaho Falls
No. A.O.S. 15p. St.

Registration District No. 73 State File No. 161747

(If born in hospital or institution
give name.)

Prim. Registration District No. 2, 1, 1, 2 Local Registrar's No. 217

FULL NAME OF CHILD Deering, Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>April 15 1928</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living _____

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Deering, Manuel
Residence (Usual place of abode) R. 1. Idaho Falls

If nonresident, give place and State _____

Color or race White Age at last Birthday 20 (Years)

Birthplace Idaho (City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Deering, Gladys
Residence (Usual place of abode) R. 1. Idaho Falls

If nonresident, give place and State _____

Color or race White Age at last Birthday 19 (Years)

Birthplace Idaho (City and State or Country)

Occupation Homemaker

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 11:22 P. M. on the date above stated.

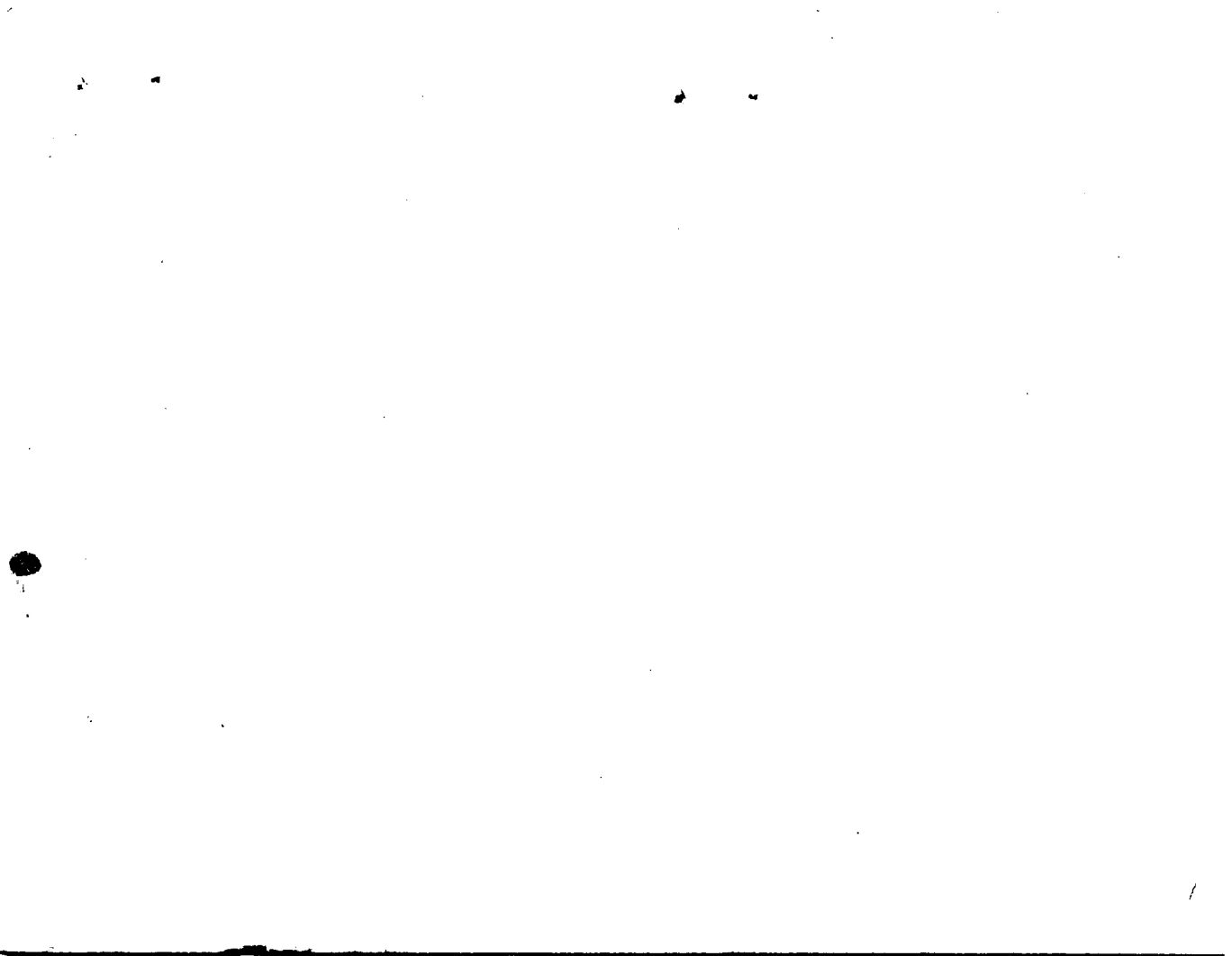
(Signature) [Signature]

(Physician or midwife)

Address Idaho Falls

Filed 21 1928 Registrar [Signature]

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED MAY 16 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 61790

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 1Local Registrar's No. 7(If death occurred in a hospital or institution, give its name instead of street and number.)
He. N. S. Hospital2. FULL NAME Infant Glenning(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) April 15 19287. AGE Years Months Days Less than 1 day

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls
(State or country) Idaho

PARENTS

10. NAME OF FATHER Manuel Glenning11. BIRTHPLACE OF FATHER (city or town) Ammon Ida
(State or Country)12. MAIDEN NAME OF MOTHER Gladys Nelson13. BIRTHPLACE OF MOTHER (city or town) Lincoln Ida
(State or Country)14. Informant Mr. P. C. Nelson
(Address) Lincoln Idaho15. Filed Apr. 16, 1928 W. F. M. Han Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 15 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 1928, to 19that I last saw him alive on 19and that death occurred, on the date stated above, at deliveryTHE CAUSE OF DEATH* was as follows:
Still Born. (Premature about 6 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. C. Nelson, M. D.4/16 1928 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Ammon Idaho 4/16 192820. Undertaker P. F. M. Han Address Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

413-110-010-154
PLACE OF BIRTH

County of Ben
City of Idaho Falls

No. _____ St. _____

(If born in hospital or institution give name.)

Registration District No. 73

State File No. _____

Prim. Registration District No. 214

Local Registrar's No. 26

FULL NAME OF CHILD Mathiasen Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>April 10 1928</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Mathiasen, Lyggaard

Residence (Usual place of abode) Idaho Falls

If nonresident, give place and State _____

Color or race white Age at last Birthday 35 (Years)

Birthplace Denmark
(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Andersen, Elva J.

Residence (Usual place of abode) Idaho Falls

If nonresident, give place and State _____

Color or race white Age at last Birthday 28 (Years)

Birthplace Illinois
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at 7 9 M.

(Signature) M. Hollister

M. A.
(Physician or midwife)

Address Idaho Falls, Ida.

Filed Apr 12 1928 A. J. Hansen Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATEMENT OF BIRTH

Registration Number: _____

Local Health Officer: _____

It is hereby certified that _____

Date of Birth: _____
 Place of Birth: _____
 Sex: _____

Parents: _____
 Mother: _____
 Father: _____

It is further certified that _____

STATEMENT OF ATTENDING PHYSICIAN OR MIDWIFE

(Name) _____

I hereby certify that I attended the birth of this child, who was (Name) _____

on the date above stated.

(Signature)

I further certify that I attended the birth of this child, who was (Name) _____ on the date above stated.

(Signature of physician)

Address _____

City _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH				DO NOT WRITE IN THIS SPACE State File No. <u>61797</u>	
RECEIVED MAY 16 1928 PLACE OF DEATH					
County of <u>Bonneville</u>		Registration District No. <u>13</u>		Local Registrar's No. <u>U-3</u>	
City of <u>Idaho Falls</u>		Primary Registration District No. <u>21 V-2</u>			
(No. <u>G. V. S. Hospital</u>) (If death occurred in a hospital or institution, give its name instead of street and number.)					
2. FULL NAME <u>Anton Mathiesean</u>					
(a) Residence. No. <u>Gona Idaho</u> St. <u></u>					
(Usual place of abode)					
Length of residence in city or town where death occurred. yrs. <u>1</u> mos. <u>1</u> ds. How long in U. S., if of foreign birth? yrs. mos. ds.					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>male</u>		4. COLOR OR RACE <u>white</u>		5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>	
6a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>none</u>					
6. DATE OF BIRTH (month, day and year) <u>April 10 1928</u>					
7. AGE Years <u>0</u>		Months <u>0</u>		Days <u>0</u>	
8. OCCUPATION OF DECEASED <u>none</u>					
(a) Trade, profession, or particular kind of work					
(b) General nature of industry, business, or establishment in which employed (or employer)					
(c) Name of employer					
9. BIRTHPLACE (city or town) <u>Idaho Falls</u> (State or country)					
10. NAME OF FATHER <u>Induverd Mathiesean</u>					
11. BIRTHPLACE OF FATHER (city or town) <u>Denmark</u> (State or Country)					
12. MAIDEN NAME OF MOTHER <u>Elmore Anderson</u>					
13. BIRTHPLACE OF MOTHER (city or town) <u>Illinois</u> (State or Country)					
14. Informant <u>Induverd Mathiesean</u> (Address) <u>R. V. 2 Idaho Falls</u>					
15. Filed <u>4/10</u> , 19 <u>28</u> <u>Certified</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH <u>April 10 1928</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>4-10</u> , 19 <u>28</u> , to <u>4-10</u> , 19 <u>28</u> that I last saw <u>live</u> on <u>still born</u> , 19 <u>28</u> and that death occurred, on the date stated above, at <u>7</u> # <u>7</u> m. The CAUSE OF DEATH* was as follows: <u>Still born</u> (duration) yrs. mos. ds. CONTRIBUTORY <u>Premature</u> (Secondary) (duration) yrs. mos. ds.					
18. Where was disease contracted if not at place of death? Did an operation precede death? Date of Was there an autopsy? What test confirmed diagnosis? <u>Dr. Hallister</u> M. D. (Signed) <u>4/10</u> , 19 <u>28</u> (Address) <u>Idaho Falls, Idaho</u>					
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
19. Place of Burial, Cremation, or Removal <u>Idaho Falls</u>				Date of Burial <u>4/10 28</u>	
20. Undertaker <u>V. F. McHann</u>				Address <u>Idaho Falls</u>	

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

296-12200-759
PLACE OF BIRTH JUN 12 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Bonanza

City of Woodville

CERTIFICATE OF BIRTH

No. St. Registration District No. 73 State File No. 161774

Hospital Primary Registration District No. 2142 Local Registrar's No. 319

FULL NAME OF CHILD Stillborn & Broc Blanch

(Certificate of no value without full name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>5-22</u> 192 <u>8</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME J. Gordon Brockbank
RESIDENCE Shelley R 3
COLOR white AGE AT LAST BIRTHDAY 19 (Years)
BIRTHPLACE Spanish Fork Utah
OCCUPATION farm laborer

MOTHER
FULL MAIDEN NAME Stella Anderson
RESIDENCE Shelley R 3
COLOR white AGE AT LAST BIRTHDAY 22 (Years)
BIRTHPLACE Provo Utah
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 12 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Edwin Cutler M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Shelley

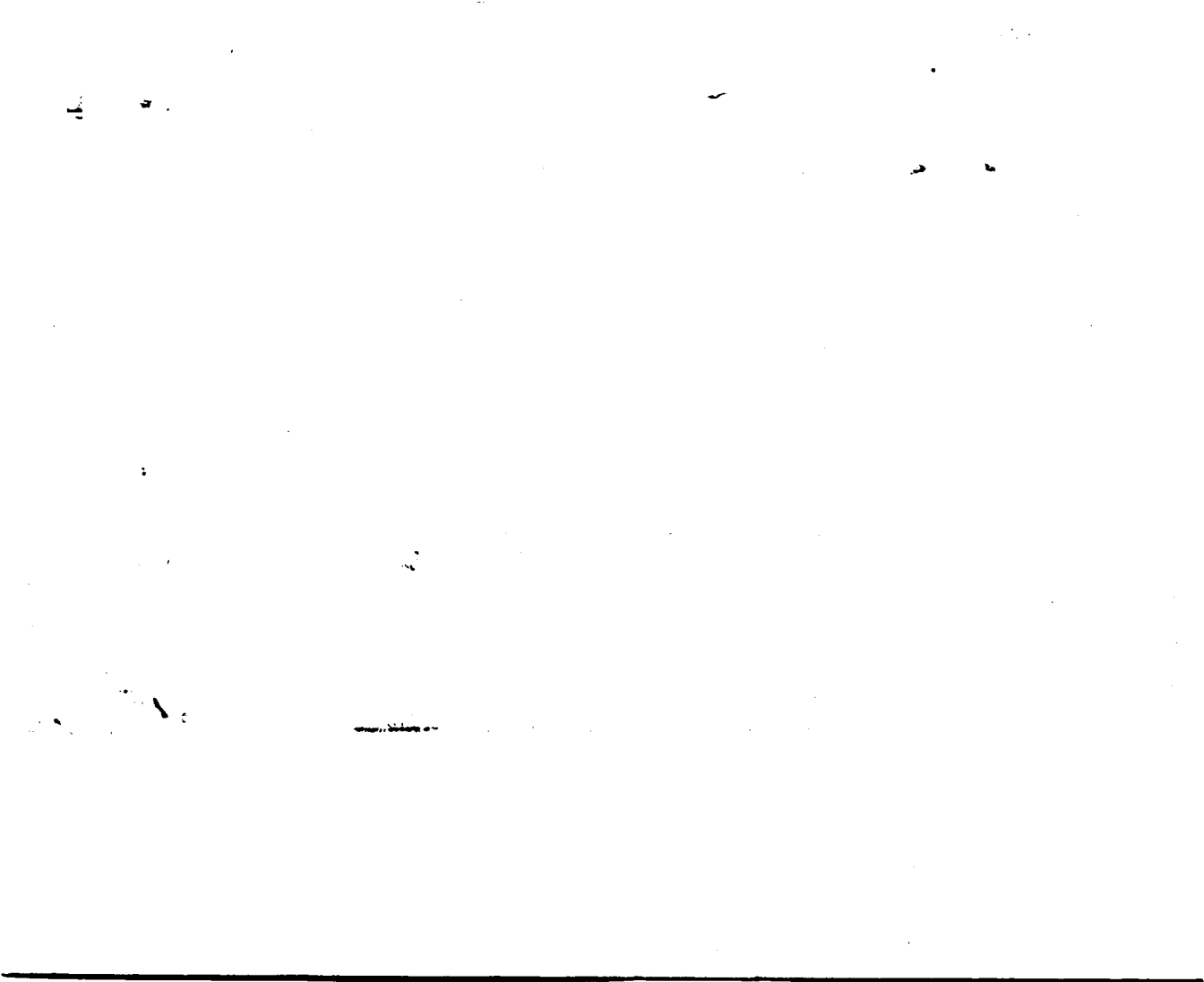
Filed

6/11

1928

Registrar.

Registrar.



RECORDED JUL 3 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **62189**

PLACE OF DEATH

County of *Bannock*

City of *Woodville*

Registration District No. *23*

Primary Registration District No. *23-0*

Local Registrar's No. *90*

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. *75* *Woodville* St.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. Single, Married, Widowed, or Divorced (write the word) *Still born*

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) *5-22-1928*

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) *Woodville Bannock Co.*

10. NAME OF FATHER *J. Gardiner Brookbank*

11. BIRTHPLACE OF FATHER (city or town) (State or Country) *Spanish Fork Utah*

12. MAIDEN NAME OF MOTHER *Ester Anderson*

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) *Provo Utah Mapleton*

14. Informant *L. K. Anderson* (Address) *P.O. Shelley*

15. Filed *5/23*, 19 *28* *W. L. Anderson* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5-22-1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Still born, 19 *28*
that I last saw him alive on *Still born*, 19 *28*
and that death occurred, on the date stated above, at *Still born* m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *W. L. Anderson* M. D.

5/23, 19 *28* (Address) *Shelley*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Woodville Cemetery *5/23*, 19 *28*

20. Undertaker Address

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUN 12 1928

PLACE OF BIRTH
County of Bonneville
City of Edinboro Falls
No. 485 101 010 396 St. L.O.S. 16p

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S** 161852

Registration District No. 73 State File No. _____
Prim. Registration District No. 2 1 1 2 Local Registrar's No. 2 7 1

FULL NAME OF CHILD Dye, Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>May 1 1928</u> (Month) (Day) (Year)
--------------------------	---	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living _____
Born alive but now dead _____ Stillborn 1

FATHER	MOTHER
FULL NAME <u>Dye, Clyde</u>	FULL MAIDEN NAME <u>Craft, Ellen</u>
Residence (Usual place of abode) <u>Shelley R. 2.</u>	Residence (Usual place of abode) <u>Shelley R. 2</u>
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>white</u> Age at last Birthday <u>19</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>22</u> (Years)
Birthplace <u>Idaho</u> (City and State or Country)	Birthplace <u>Idaho</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ^{Born alive} Stillborn at 8:30 P. M. on the date above stated.

(Signature) Edwin Cutler M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Shelley
Filed 7 1 1928 Registrar.

5012

FORM V. S. No. 5-25, M. 1-19.

JUL 3 1928

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 214-2
(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2188
Registered No. 91

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Dye

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Born (Write the word.)

6. DATE OF BIRTH

5 1 1928
(Month) (Day) (Year)

7. AGE

Stillb. born IF LESS than 1 day
Yrs. Mos. ds. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Babe

9. BIRTHPLACE

(State or Country) Idaho Falls Id.

10. NAME OF FATHER

Clyde Edward Dye

11. BIRTHPLACE OF FATHER

(State or Country) Firth Id.

12. MAIDEN NAME OF MOTHER

Ellen Croft

13. BIRTHPLACE OF MOTHER

(State or Country) Basalt Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. T. Dye
R. 2 Shelley

(Address)

15.

Filed 6/1-1928 Idaho Falls
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 1-1928
Idaho Falls
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

Delivered instrumentally
that I last saw him alive on 19 19 19
and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:

Eclampsia of
pregnancy

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edwin Butler M. D.

5/2-1928 (Address) Shelley Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls 5-2-1928

20. UNDERTAKER

ADDRESS

none employed

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

418 527 214-396
PLACE RECEIVED

RECEIVED JUN 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S-
161914

County of Canyon Co

City of Merba

No. _____ St. _____

Registration District No. 7

File No. _____

Hospital _____

Primary Registration District No. 2006

Registered No. 79

FULL NAME OF CHILD

Unnamed Mahler

(Certificate of no value without full name of child.)

Sex of Child

M

Twin
Triplet
or other?

{ and }

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

May 27 1928

(Month) (Day) (Year)

What bacteriocidal solution was used in eyes?

no

Number of child of this mother, including present birth

7

Number of child of this mother now living, including present birth

6

FULL
NAME

FATHER Mike Alven Mahler

FULL
MAIDEN
NAME

MOTHER Mary Adeline Troxel

RESIDENCE

R.D. 1 Kunam Canyon Co.

RESIDENCE

R.D. 1 - Kunam (In Canyon Co)

COLOR

White

AGE AT LAST
BIRTHDAY

48

(Years)

COLOR

White

AGE AT LAST
BIRTHDAY

40

(Years)

BIRTHPLACE

Ohio

BIRTHPLACE

Kansas

OCCUPATION

Rancher (Is a Carpenter)

OCCUPATION

Rancher's Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.

Stillborn 8:15 P.M.

{ *When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth. }

(Signature)

O.R. Meredith M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Idaho

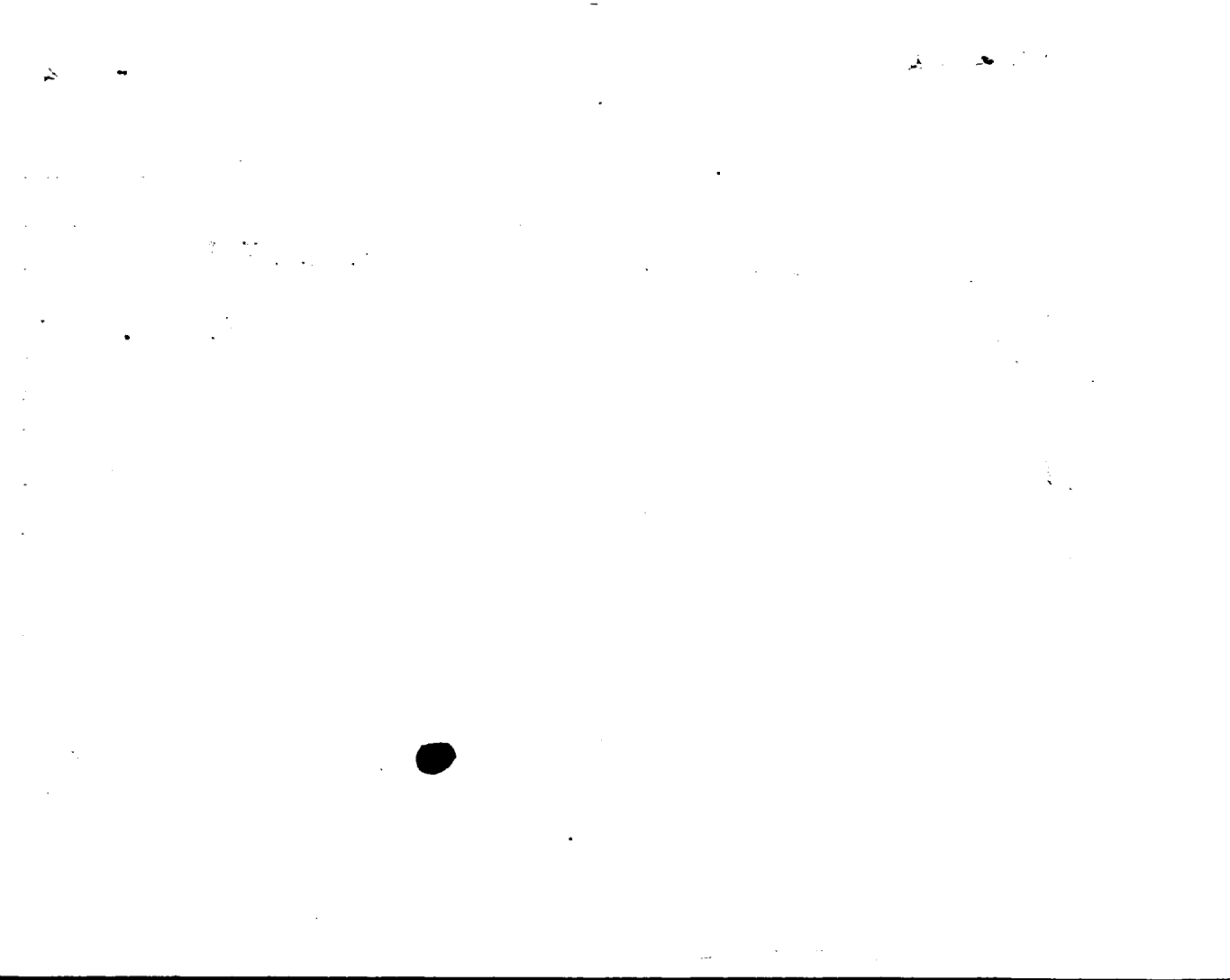
Filed

6-4 1928

Mae Gerby

Registrar.

Registrar.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 61826

County of Canyon

Registration District No. 1

City of east of ...

Primary Registration District No. 2006

(No. 7 miles so east)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 59

2. FULL NAME Baby Mahler

(a) Residence. No. 7 miles so east St.

(Usual place of abode)

(If nonresident give city of town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. Single, Married, Widowed, or Divorced (write the word)

single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

May 27 1928

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

Idaho

10. NAME OF FATHER

M.A. Mahler

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Mary A. Troxel

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

Kansas

14.

Informant

Mr. M.A. Mahler

(Address)

R.F.D. #1 Lima Idaho

15.

Filed

6-5 1928 Mae Terry

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 27 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth May 27 1928

that I last saw him alive on

and that death occurred, on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Still born

CONTRIBUTORY
(Secondary)Mother struck by
auto Nov 30 192718. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. Meredith D.

5-78 1928 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Kohlerlawn-Nampa 5-28 1928

20. Undertaker

Address

Wm D. Talley Nampa, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return, "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia." "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: "Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUN 6 1928

STATE OF IDAHO

County of Adair

City of Osley

No. 418 127 016-215 St.

(If born in hospital or institution
give name.)

Registration District No. 12 State File No. S161970

Prim. Registration District No. 299 Local Registrar's No. 26

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate?	Date of birth (Month) (Day) (Year)
					<u>May 27 1928</u>

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 8 (a) Born alive and now living 5

Born alive but now dead None Stillborn

FULL NAME <u>Ben Dayley</u>	FATHER	FULL MAIDEN NAME <u>Mother Sanford</u>	MOTHER
-----------------------------------	--------	---	--------

Residence (Usual place of abode) Cheshill, Id

If nonresident, give place and State

Color or race White Age at last Birthday 47 (Years)

Birthplace Idaho (City and State or Country)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 8.15 a M.
on the date above stated.

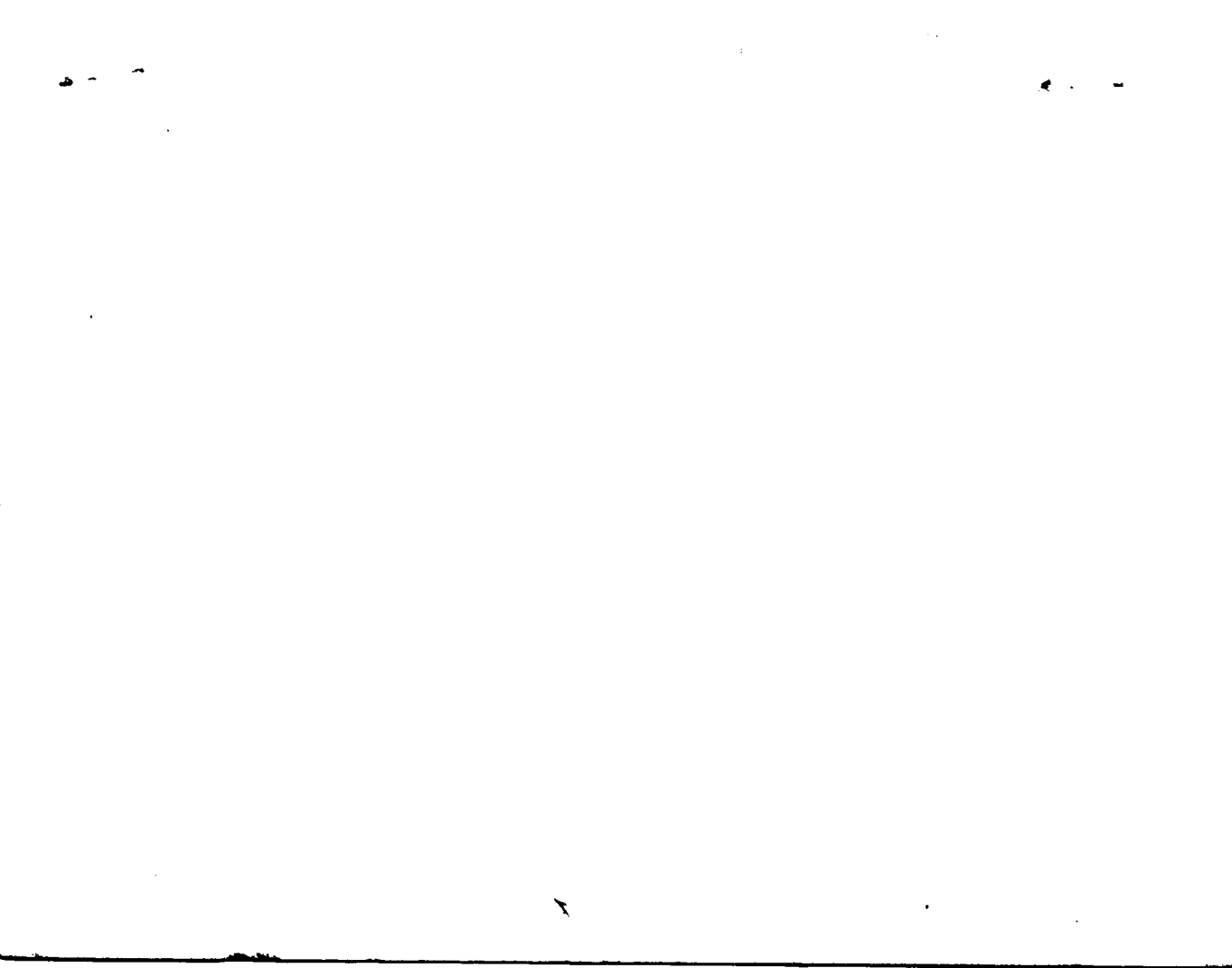
(Signature) [Signature]

(Physician or midwife)

Address Osley, Idaho

File [Signature] 1928 Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 61846RECEIVED
PLACE OF DEATH JUN 6 1928

CERTIFICATE OF DEATH

County of CamiaRegistration District No. 17City of OakleyPrimary Registration District No. 2199Local Registrar's No. 9(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. No Name St. Oakley, Id.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

May 27 - 1928

7 AGE

Still born

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Oakley, Idaho

10 NAME OF FATHER

Ben Dayley11 BIRTHPLACE OF FATHER (city or town)
(State or country)Idaho

12 MAIDEN NAME OF MOTHER

Martha Sanford13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Idaho14 Informant
(Address)Mrs Ben Dayley
Oakley, Idaho15 Filed June 4, 1928M. A. Johnson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May
(Month)27
(Day)28
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19_____,

that I last saw him alive on _____, 19_____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed)

May 31, 1928

(Address)

Oakley, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Oakley, Id.

Date of Burial

May 29, 1928

20. Undertaker

Ben Dayley

Address

Oakley, Id.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

419-212-019-295
PLACE OF BIRTH

RECEIVED JUN 11 1928
County of Custer

City of Clayton

No. 1 St. 108

Hospital Unnamed

FULL NAME OF CHILD Unnamed

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? and { Number in order of birth 1 }
(To be answered only in event of plural births)

Legitimate? yes Date of birth April 13 1928
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 2

FATHER
FULL NAME Andrew Maraffio
RESIDENCE Clayton
COLOR White AGE AT LAST BIRTHDAY 44
(Years)
BIRTHPLACE Vila, Italy
OCCUPATION Ranching

MOTHER
FULL MAIDEN NAME Mary Bini
RESIDENCE Clayton
COLOR White AGE AT LAST BIRTHDAY 36
(Years)
BIRTHPLACE Vila, Italy
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 11 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

Registarr.

Registarr.

STATE OF LOUISIANA
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

2

182020

Registration Number No. _____ State File No. _____
 Primary Hospital District No. _____
 FULL NAME OF CHILD _____
 Sex of Child _____
 Date of Birth _____
 (Month) (Day) (Year)
 (To be answered only in event of stillbirth)

What pathological condition was found in event?
 Number of child of this mother including present birth _____
 FULL NAME OF MOTHER _____
 Number of child of this father including present birth _____
 FULL NAME OF FATHER _____

RESIDENCE _____
 COLOR _____ AGE AT LAST BIRTHDAY _____
 BIRTHPLACE _____
 COLOR _____
 BIRTHPLACE _____
 OCCUPATION _____
 OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was _____ at _____
 (Physician or midwife)
 Address _____
 When there was no attending physician or midwife, then the father, householder, or another male citizen, A child born to a woman who is not married, and not a widow, shall be considered as illegitimate.
 Give names and dates of subsequent reports

RECEIVED IN THE OFFICE OF THE CLERK OF THE SUPREME COURT OF THE STATE OF LOUISIANA, AT NEW ORLEANS, THIS 10th DAY OF JANUARY, 1920.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 11 1928

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 61863

County of *Custer*

City of *Clayton*

Registration District No. *108*

Primary Registration District No. *21865*

Local Registrar's No. *74*

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Not Named

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White Italian* 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) *April 12 1928*

7. AGE Years Months Days If LESS than 1 day, hrs. or
0 0 0 Italian

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) *Custer Co. Idaho*

10. NAME OF FATHER *Andrew Maraffio*

11. BIRTHPLACE OF FATHER (city or town) (State or Country) *Vila, Italy*

12. MAIDEN NAME OF MOTHER *Mary Gini*

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) *Vila, Italy*

14. Informant *Andrew Maraffio*
(Address) *Clayton, Idaho*

15. Filed *April 13, 1928* *Edna M. Kenney*
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *April 12 1928*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to 19.....

that I last saw him alive on 19.....

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Heart failure
due to
myocardial infarction
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Edna M. Kenney* M. D.

....., 19..... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial
April 12 1928

20. Undertaker Address
Relatives Clayton, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

619 122 020-815
PLACE OF BIRTH

RECEIVED MAY 16 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of Elmore

City of Glenn's Ferry

No. _____ St.

Registration District No. 36

File No. S162023

Hospital _____

Primary Registration District No. 2021

Registered No. _____

FULL NAME OF CHILD

Franklin Orr Farnsworth

(Certificate of no value without full name of child.)

Sex of Child <u>male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and {	Number in order of birth <u>1</u>	Legiti- mate? <u>yes</u>	Date of birth <u>April 22</u> 192 <u>8</u> (Month) (Day) (Year)
--------------------------	---	-------	---	-----------------------------	---

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth 0

FATHER
FULL NAME Lewis Franklin Farnsworth

MOTHER
FULL MAIDEN NAME Rosetta Hansen

RESIDENCE Glenn's Ferry Idaho

RESIDENCE Glenn's Ferry Idaho

COLOR white AGE AT LAST BIRTHDAY 36 (Years)

COLOR white AGE AT LAST BIRTHDAY 24 (Years)

BIRTHPLACE Utah

BIRTHPLACE Idaho

OCCUPATION Mach. Helper

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was April 22, 1928 at Glenn's Ferry Idaho P M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. W. Davis
Physician
(Physician or midwife)

Give names added from a supplemental report.

Address Glenn's Ferry Idaho

Filed April 24, 1928 J. W. Davis
Registrar.

Registrar.

CLING TO BELIEF 134

19-220
19-221

1-10-68

1945

12-11-1964

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SECRET

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TRAJ. TA. DE
YACHTING

FROM Q2

FRANK A. GONZA
YOUNG, JR.

014741

MODIFIED

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I have a great deal of work to do and I am very busy.

1. The first group of people who were
2. the first to be killed were the
3. the first to be killed were the
4. the first to be killed were the

(28/11/1942)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 16 1928

FORM V. S. NO. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Elmore
City of Elmer's Ferry

Registration District No. 35

Primary Registration District No. 2021

(No. _____ St.)

State File No. 61870

Local Registrar's No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin Ole Farnsworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male White Single
(Write the word)

6. DATE OF BIRTH

April 22 1928
(Month) (Day) (Year)

7. AGE

Still Born IF LESS than 1 day how many
hrs. or min.?
Yrs. Mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF Father

Lewis Franklin Farnsworth

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Rauda Hamer

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis Franklin Farnsworth

(Address) Elmer's Ferry Idaho

15. Filed April 23 1928 J. W. Davis

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 22 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 22 1928 to April 22 1928

that I last saw ~~him~~ alive on April 22 1928

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum
Was able to recognize life
about one hour before birth
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Davis M. D.

23 1928 (Address) Elmer's Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. days. State yrs. mos. ds.

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Elmer's Ferry Idaho

DATE OF BURIAL April 24 1928

20. UNDERTAKER

E. C. Zacher

ADDRESS McNamee Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner**, (b) **Cotton Mill**; (a) **Salesman**, (b) **Grocery**; (a) **Foreman**, (b) **Automobile factory**. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)**. For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia**; **Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc.**, **Carcinoma, Carcoma, etc.**, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles**; **Whooping cough**; **Chronic valvular heart disease**; **Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.**; **Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia**," "**PUERPERAL peritonitis**," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning**; **struck by railway train—accident**; **Revolver wound of head—homicide**; **Poisoned by carbolic acid—probably suicide**. The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE HERE

MAY 17 1928

STATE OF IDAHO

County of Idaho

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

City of Kootenai

CERTIFICATE OF BIRTH

S 162106

No. St.

855-113 025-313

Registration District No. 106 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 2184 Local Registrar's No. 193

FULL NAME OF CHILD

Still birth

(If stillborn substitute the word "Stillbirth" for name of child)

Sex of
Child

Male

Twin
Triplet
or other?
(To be answered only in event of plural births)

and

Number
in order
of birth

Legiti-
mate?

Date of
birth

(Month)

(Day)

(Year)

April 13 1928

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth ONE (a) Born alive and now living None

Born alive but now dead None Stillborn ONE

FATHER
FULL NAME George Young

MOTHER
FULL MAIDEN NAME Della Caldwell

Residence (Usual place of abode)

Residence (Usual place of abode)

If nonresident, give place and State

If nonresident, give place and State

Color or race White Age at last Birthday 24

Color or race White Age at last Birthday 26

Birthplace Kootenai Idaho
(City and State or Country)

Birthplace Idaho
(City and State or Country)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8:10 a.m.
on the date above stated.

(Signature) J. M. Verbeek

Physician
(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address Kootenai Idaho

Filed May 1 1928 J. M. Verbeek
Registrar.

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
155 E. 42ND STREET
NEW YORK 17, N.Y.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 17 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 61889

County of Idaho

City of Kootenai

Registration District No. 106

Primary Registration District No. 2184

Local Registrar's No. 256

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Fuller

(a) Residence. No.

St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 13 - '28

7. AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Kootenai Idaho (State or country)

10. NAME OF FATHER

George Young

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Bella Calder

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

Idaho

14.

Informant

(Address)

George Young Kootenai - Idaho

15.

Filed

April 15, 1928

J. M. Hubert

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April

13

1928

17. I HEREBY CERTIFY, That I attended deceased from

19, to 19

that I last saw him alive on 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Fuller

CONTRIBUTORY (Secondary)

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

April 15, 1928 J. M. Hubert M. D. (Address) Kootenai - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Idaho Cemetery

April 14, 1928

20. Undertaker

Address

Family

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

819 131025-396
PLACE OF BIRTH

County of Idaho
City of Kootenai
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

162118

RECEIVED JUN 12 1928

Registration District No. 106 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 2184 Local Registrar's No. 202

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>May 31</u> 19 <u>28</u> (Month) (Day) (Year)
--------------------------	---	---	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver Nitrate

Number of child of this mother, including present birth One (a) Born alive and now living _____

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME Edward Harris

MOTHER
FULL MAIDEN NAME Alma Crook

Residence (Usual place of abode) Kootenai

Residence (Usual place of abode) Kootenai

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race White Age at last Birthday 31
(Years)

Color or race White Age at last Birthday 24
(Years)

Birthplace Colorado
(City and State or Country)

Birthplace Idaho Co. Idaho
(City and State or Country)

Occupation Salvage

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive ☒ Stillborn ☐ at _____ 1 P. M.
on the date above stated.

(Signature) J. M. Leberkue

Physician
(Physician or midwife)

Address Kootenai Idaho

Filed June 1 1928 J. M. Leberkue
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

1. From Registration District No. 1, 1st Local Division

...and the "Revolution" ... only one ...

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----

1. The first of these is the fact that the Government has been unable to secure the necessary funds to carry out its policy of non-alignment. This is due to the fact that the Government has been unable to secure the necessary funds to carry out its policy of non-alignment.

THE JOURNAL OF THE
ROYAL ANTHROPOLOGICAL INSTITUTE
OF GREAT BRITAIN AND IRELAND
VOLUME 100 PART 1 2000

(b) (6), (b) (7)(C)

II. RECOMMENDATIONS

(Date in use) _____

no. 100-100000

RECEIVED BY ATTORNEY GENERAL

is ~~not~~ ~~the~~ ~~only~~ ~~kind~~ ~~and~~ ~~to~~ ~~draw~~ ~~out~~ ~~information~~ ~~from~~ ~~these~~ ~~persons~~

(S. 100)

[illegible]

SECRET

...the ...
...the ...
...the ...
...the ...

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 62886

PLACE OF DEATH
County of Idaho
City of Kootenai

Registration District No. 106
Primary Registration District No. 2184

Local Registrar's No. 257

(No. 106)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. Sullivan

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

May 21 - 1928

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)Kootenai Idaho

10. NAME OF FATHER

Edward Harris11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Colorado

12. MAIDEN NAME OF MOTHER

Alma Grant13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Idaho Co - Idaho14. Informant
(Address)Alma Harris
Kootenai

15. Filed

June 1, 1928J. M. Weber
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May311928

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19 , to , 19

that I last saw h. alive on , 19

and that death occurred, on the date stated above, at .m.

The CAUSE OF DEATH* was as follows:

"Sullivan"Fetus legally measured, probably
died 7-10 days.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. M. Weber

M. D.

May 311928(Address) Kootenai Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Kootenai CemeteryMay 311928

20. Undertaker

Address

Sammy

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

not numbered

PLACE OF BIRTH
County of Jefferson
City of Reggie
No. 814-207026364 St. JUN 8 1928
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S**
Registration District No. 98 State File No. 162124
Prim. Registration District No. 2176 Local Registrar's No. 92

FULL NAME OF CHILD _____
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Girl</u>	Twin <u>X</u> Triplet <u>X</u> or other <u>X</u>	and {	Number in order of birth <u>1</u>	Live <u>X</u> or stillborn <u>X</u>	Date of birth <u>Mar 7 28</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? 0

Number of child of this mother, including present birth 6 (a) Born alive and now living 5
Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Melvin Hancock</u>	MOTHER FULL NAME <u>Margaret Cornell</u>
---	---

Residence (Usual place of abode) Reggie, Ida

If nonresident, give place and state _____

Color or race white Age at last Birthday 31 (Years)

Birthplace Utah (City and State or Country)

Occupation farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 6 9 M.
on the date above stated.

(Signature) Samuel Trice

(Physician or midwife)

Address Reggie, Idaho

Filed 6-1 19 28 W. W. Wain

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(over)

Stillborn - six weeks premature
death supposed to have been
caused by a fall.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF RECEIPT		STATE OF IDAHO		
JUN 8 1928		DEPARTMENT OF PUBLIC WELFARE		
BUREAU OF VITAL STATISTICS		CERTIFICATE OF BIRTH		
County of <u>Jefferson</u>		Registration District No. <u>98</u> State File No. <u>162139</u>		
City of <u>Pegley</u>		Prim. Registration District No. <u>2176</u> Local Registrar's No. <u>112</u>		
No. <u>313 205026 313</u> St.		Full Name of Child <u>Stillbirth</u> (<u>Placenta Praevia</u>)		
(If born in hospital or institution give name.)		(If stillborn, substitute the word "Stillbirth" for name of child)		
Sex of Child <u>Female</u>	Twin Triplet or other <u>✓</u>	Number in order of birth <u>1</u>	Legitimate <u>yes</u>	Date of birth <u>Mar. 5</u> 19 <u>28</u>
(To be answered only in event of plural births)		(Month) (Day) (Year)		
What prophylactic was used to prevent Ophthalmia Neonatorum? <u>—</u>				
Number of child of this mother, including present birth <u>8</u> (a) Born alive and now living <u>5</u>				
Born alive but now dead <u>1</u> Stillborn <u>2</u>				
FATHER		MOTHER		
FULL NAME <u>Irus S. Later</u>		FULL MAIDEN NAME <u>Chloe C. Later</u>		
Residence (Usual place of abode) <u>Pegley Idaho</u>		Residence (Usual place of abode) <u>Pegley Idaho</u>		
If nonresident, give place and State		If nonresident, give place and State		
Color or race <u>White</u> Age at last Birthday <u>40</u> (Years)		Color or race <u>White</u> Age at last Birthday <u>38</u> (Years)		
Birthplace <u>Asiatic, Utah</u> (City and State or Country)		Birthplace <u>Pegley Idaho</u> (City and State or Country)		
Occupation <u>Farmer</u>		Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 10:30 P. M. on the date above stated.

(Signature) H. R. West

M. D.
(Physician or midwife)

Address Pegley Idaho

Filed 6-1 1928 Edw. Larin

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

When there was no attending physician, or midwife, then the father himself, or a stillborn child, should make the return. A stillborn child is one that neither breathed nor showed any other signs of life after birth.

I hereby certify that I attended the birth of this child, who was born on the date and at the place stated.	
(Signature) _____	
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE	
Registered (State or Country) _____	Registered (State or Country) _____
Discharged _____	Discharged _____
Color of race _____	Color of race _____
Age at last birthday _____	Age at last birthday _____
In no condition, the child, and state _____	In no condition, the child, and state _____
(Indicate place of birth) _____	(Indicate place of birth) _____
FULL NAME _____	FULL NAME _____
Number of child of this mother _____	Number of child of this mother _____
What proceedings were taken to prevent (Indicate) _____	What proceedings were taken to prevent (Indicate) _____
(If child was born only in event of illness) _____	(If child was born only in event of illness) _____
It is requested to indicate the words "Stillborn" in space of child _____	It is requested to indicate the words "Stillborn" in space of child _____
Print Registration District No. _____	Print Registration District No. _____
Registration District No. _____	Registration District No. _____

FORM V. S. No. 5-2

RECEIVED APR 4 1928

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Jefferson
City of RegleyRegistration District No. _____
Primary Registration District No. 2176
(No. _____ St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 20962
Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

SteelbirthLocal 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Mar. 5 1928
(Month) (Day) (Year)

7. AGE

Steelbirth
Yrs. _____ Mos. _____ ds. _____IF LESS than 1 day
how many _____ hrs.
or _____ min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work. _____
(b) General nature of industry, business or establishment in which employed (or employer). _____

9. BIRTHPLACE

(State or Country) Regley, Idaho

10. NAME OF FATHER

Louis S. Luter

11. BIRTHPLACE OF FATHER

(State or Country) Henrieville, Utah

12. MAIDEN NAME OF MOTHER

Chloe C. Luter

13. BIRTHPLACE OF MOTHER

(State or Country) Regley, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father Louis Luter

(Address) _____

15.

Filed H-1 28 1928

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 5 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Steelbirth to _____ 19____
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Steelbirth 8 months due to (Placenta Praevia).

_____. (Duration) _____ Yrs. _____ mos. _____ ds.

Contributory _____
(Secondary)

_____. (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. R. West M. D.1928 (Address) Regley, Idaho

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Regley

DATE OF BURIAL

4/6 1928

20. UNDERTAKER

None

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUN 6 1928

PLACE OF BIRTH
County of Kootenai
City of Coeur d'Alene
No. 994-116028866 St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Home Hospital
(If born in hospital or institution give name.)

Registration District No. 30 State File No. 162178

Prim. Registration District No. 1057 Local Registrar's No. 98

FULL NAME OF CHILD

Still born

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child

Male

Twins
Triplet
or other?
(To be answered only in event of plural births)

Number
and in order
of birth

Legitimate?

Date of birth

May
(Month)

16
(Day)

1928
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 4

(a) Born alive and now living

Born alive but now dead

Stillborn

Still born

FATHER

FULL NAME

Amos Riddell

Residence (Usual place of abode)

Coeur d'Alene

If nonresident, give place and State

Color or race white

Age at last Birthday 45

(Years)

Birthplace

Indiana

(City and State or Country)

Occupation

Laborer

MOTHER

FULL MAIDEN NAME

Fannie Howerton

Residence (Usual place of abode)

Coeur d'Alene

If nonresident, give place and State

Color or race White

Age at last Birthday 34

(Years)

Birthplace

(City and State or Country)

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at 9 A. M.

(Signature)

Harold J. Sturges M.D.
Physician

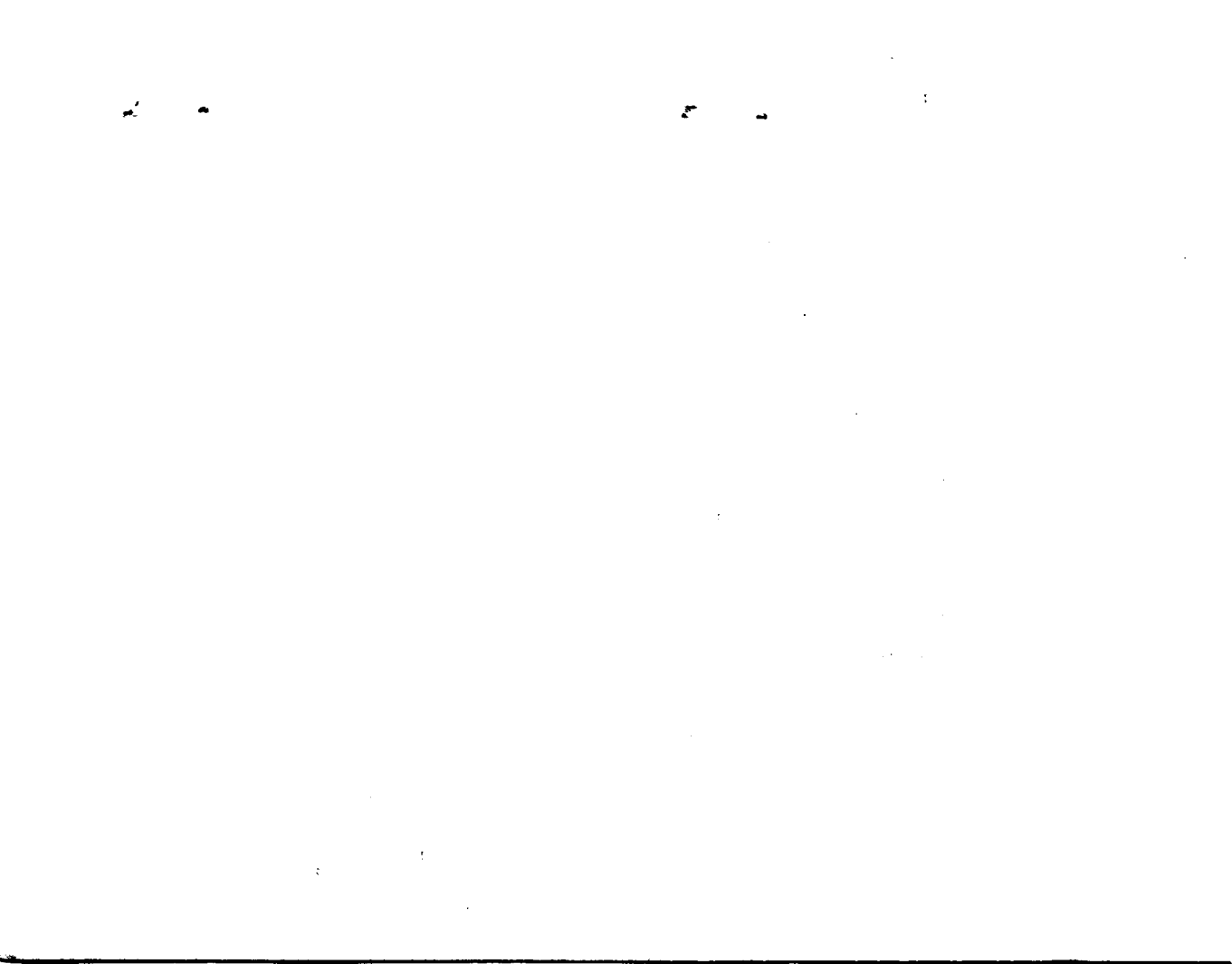
(Physician or midwife)

Address Coeur d'Alene, Idaho

Filed 6/4 1928 W.D. Brennan

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JUN 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

61915

State File No.

Local Registrar's No. 73

PLACE OF DEATH

County of Keetenai

City of Coeur D' Alene

Registration District No. 20

Primary Registration District No. 1051

(No. Home Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Riddell

(a) Residence. No. St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

XXX

6 DATE OF BIRTH (month, day and year) May 15, 1927

7 AGE

Years

Months

Days

If LESS than
1 day, 0 hrs.
or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Coeur D' Alene
(State or country) Idaho

10 NAME OF FATHER

Amos Riddell

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Mo.

12 MAIDEN NAME OF MOTHER

Fannie Hewerton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Mo.

14 Informant Amos Riddell

(Address) Coeur D' Alene, Ida.

15 Filed 5/26, 1928 W.D. Brennan
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May
(Month)

15
(Day)

1928
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 19....., to 19.....

that I last saw him alive on 19.....

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still born due to toxemia of mother

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harold J. Sturges, M. D.

5-18, 1928 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Forest Cemetery

May 17 1928

20. Undertaker

Address

P.B. Mooney Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

FILE # 162234

YEAR 1928

IDAHO STILLBIRTH CERTIFICATE



VOID



SEE BIRTH RECORD 1928-162334

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Idaho
City of Rupert

No. 993-125 034 238 St.

(If born in hospital or institution
give name.)

RECEIVED JUN 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 162245

Registration District No. 19 State File No. 1928

Prim. Registration District No. 2015 Local Registrar's No. 83

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>boy</u>	Twin } Triplet } or other? } (To be answered only in event of plural births)	and { Number } in order } of birth }	Legiti- mate? <u>yes</u>	Date of birth <u>5</u> <u>25</u> <u>1928</u> (Month) (Day) (Year)
-------------------------	---	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? yes

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>William Elmer Rupert</u>	MOTHER FULL MAIDEN NAME <u>Emma Mae Schult</u>
---	---

Residence (Usual place of abode) Rupert

If nonresident, give place and State Ida

Color or race white Age at last Birthday 30 (Years)

Birthplace Idaho (City and State or Country)

Occupation laborer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3:20 P. M.
on the date above stated.

(Signature) W. H. Hensley M.D.

(Physician or midwife)

Address Rupert

Filed 6-4 1928 E. H. Elmer

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. _____

Registration District No. _____

DATE OF BIRTH _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

Place of birth _____

What prophylaxis was used to prevent Ophtalmia Neonatorum?

Number of child at birth, including previous birth _____

How delivered, how dead _____

FULL NAME

FULL NAME

Residence (Usual place of abode) _____

Residence (Usual place of abode) _____

Is informant who gives birth and name _____

Is informant who gives birth and name _____

Color or race _____

Color or race _____

Birthplace _____

Birthplace _____

City and State or Country _____

City and State or Country _____

Occupation _____

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(Signature)

I hereby certify that I attended the birth of this child, who was _____

on the date above stated.

(Signature)

(Signature or initials)

Address _____

Telephone _____

* Where there was no attending physician or midwife, then the father, grandfather, etc., should make this return. A midwife, and in one that neither physician nor midwife, then certify of his or her own knowledge.

THIS IS A PRELIMINARY COPY - NOT TO BE USED FOR STATISTICAL PURPOSES

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUN 6 1928 CERTIFICATE OF DEATH.

1. PLACE OF DEATH

County of *Minidoka*
City of *Rupert* Registration District No. *19*Primary Registration District No. *2015*
(No. St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *1960*Registered No. *47*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Still Born of Wm. Chas. Rickett
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.*m.**white.**Child*
(Write the word.)

6. DATE OF BIRTH.

May 24 1928
(Month) (Day) (Year)

7. AGE

Still Born ds.IF LESS than 1 day
how many hrs. or
..... min. >

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*Still Born*

9. BIRTHPLACE

(State or Country)

Rupert Idaho

10. NAME OF FATHER

Wm. Chas. Rickett

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Emma May Scholdt

13. BIRTHPLACE OF MOTHER

(State or Country)

Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm. Chas. Rickett

(Address)

Rupert Idaho

15.

Filed

*May 30 1928**Ed E. Elmer*
Local Registrar

16. DATE OF DEATH

May 24 1928
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *May* 191..... to 191.....

that I last saw h..... alive on 191.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

*Asphyxia
from premature birth
Extraction*

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

5-29-28 (Address)*L. H. Rupp*

M. D.

*State the DISEASE CAUSING DEATH; or if deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Rupert Cemetery**May 25 1928*

20. UNDERTAKER

ADDRESS

*Wm. E. Goodman**Rupert*

1928
1876
52

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

693-219 035-254

PLACE OF BIRTH

RECEIVED

JUN 11 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Nez Perce
City of Lewiston

No. St. Registration District No. 96 State File No. 162271

Hospital St. Joseph Primary Registration District No. 1009 Local Registrar's No.

FULL NAME OF CHILD Bullborn Wilson

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? and { Number in order of birth Legiti- mate? Yes Date of birth May 19 1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Eugene Lee Wilson
RESIDENCE Lewiston
COLOR Wh AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Idaho
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Minnie Margaret Kemper
RESIDENCE Lewiston
COLOR Wh AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Wash.
OCCUPATION Wm.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 5-0 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report., 1928

(Signature) B. H. Weisager
(Physician or midwife)

Address Lewiston, Ida.

Filed June 6 1928 Susan E. Bruu Registrar.

Registrar.

THIS IS A COPY OF THE ORIGINAL RECORD OF THE BIRTH OF THE CHILD. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF VITAL STATISTICS.

CERTIFICATE OF BIRTH

No. _____

Primary Registration District No. _____

Local Registrar's Office _____

(Certificate of no value without full name of child)

Full name of child _____

Sex _____

Color _____

Birthplace _____

Occupation _____

Age at last birthday (Years) _____

Residence _____

Number of child of this mother, including present birth _____

Number of child of this mother now living, including present birth _____

Wants certified statement was used in event _____

FATHER

FULL NAME _____

RESIDENCE _____

COLOR _____

AGE AT LAST BIRTHDAY (Years) _____

BIRTHPLACE _____

OCCUPATION _____

MOTHER

FULL NAME _____

RESIDENCE _____

COLOR _____

AGE AT LAST BIRTHDAY (Years) _____

BIRTHPLACE _____

OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____

(Signature) _____

(Physician or midwife)

Address _____

State _____

City _____

Year _____

Give names added from a supplemental report _____

When the child was no attending physician or midwife then the father, mother, or other person should make this return. A statement of the child is not valid unless it shows other evidence of the birth.

St. Joseph JUN 11 1928
 PLACE OF DEATH
 County of *New pence*
 City of *Lewiston*

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. *92974*Registration District No. *96*Primary Registration District No. *1009*

Local Registrar's No. _____

(No. *St. Joseph Hospital*)
 (If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME *Premature Birth Stillbirth*(a) Residence. No. *Father Eugene Wilson St.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. Single, Married, Widowed, or Divorced (write the word)
Premature birth

5a. If married, widowed, or divorced
 HUSBAND of
 (or) WIFE of6. DATE OF BIRTH (month, day and year) *May 19- 1928*

7. AGE *Premature birth*
 Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) *Lewiston Idaho*
 (State or country)10. NAME OF FATHER *Eugene Wilson*11. BIRTHPLACE OF FATHER (city or town)
 (State or Country) *Lewiston*12. MAIDEN NAME OF MOTHER *Margaret Kemper*13. BIRTHPLACE OF MOTHER (city or town)
 (State or Country) *Washington*14. Informant *Eugene Wilson*
 (Address) *Spokane Wash*15. Filed *June 7, 1928* *Susan E Bruce*
 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 19 1928
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
 (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted
 if not at place of death? *no*Did an operation precede death? *no* Date of _____Was there an autopsy? *no*What test confirmed diagnosis? *no*

(Signed) *St. Joseph Hospital* M. D.
5/21, 1928 (Address) *Lewiston Idaho*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *Lewiston Idaho* Date of Burial *5/21 1928*

20. Undertaker *Casson Undertaking Co* Address *Lewiston*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for,
each and the number of each, in order of birth stated.

1147202 036-812
PLACE OF BIRTH

RECEIVED JUN 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 62288

County of Juniper
City of Juniper
No. 26 St. 74 Registration District No. 269 State File No. 74
Hospital Primary Registration District No. Local Registrar's No.
FULL NAME OF CHILD Baby Maddoux

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and { Number in order of birth Legitimate? Yes Date of birth May 2 1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 0

FATHER	MOTHER
FULL NAME <u>Thomas Maddoux</u>	FULL MAIDEN NAME <u>Lorena Viola Hastings</u>
RESIDENCE <u>Juniper Ida</u>	RESIDENCE <u>Juniper Ida</u>
COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>White</u> AGE AT LAST BIRTHDAY <u>22</u> (Years)
BIRTHPLACE <u>Lewistown Idaho</u>	BIRTHPLACE <u>Port Valley W Va</u>
OCCUPATION <u>Farmer</u>	OCCUPATION <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 3:30 a M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Oliver Sandteghrad

(Physician or midwife)

Address Snowville Utah

Filed 6731 1928

Registrar.

Registrar.

I hereby certify that I attended the birth of this child and was present at the time of its birth. I am a duly licensed midwife and have no other children living. I am not married and have no other children living. I am not married and have no other children living.

The names noted here are the names of the child and its mother. The names of the child and its mother are noted here. The names of the child and its mother are noted here. The names of the child and its mother are noted here.

(Signature)

(Midwife or midwife)

CERTIFICATE OF BIRTH

BIRTHPLACE		BIRTHPLACE	
AGE AT LAST BIRTHDAY		AGE AT LAST BIRTHDAY	
COLOR		COLOR	
RESIDENCE		RESIDENCE	
NAME		NAME	
MOTHER		MOTHER	
FATHER		FATHER	

Want hospitalization certificate was used in case?

Child of _____ Sex of _____
 (To be answered only in case of birth in hospital)

(Certificate of birth without full name of child)

Hospital

162288

DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS

RECEIVED JUN 6 1928

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. **PRELIMINARY DATA**
County of Oneida
City of Juniper
Registration District No. 26
Primary Registration District No. 2069
(No. _____) (St.) _____File No. 01983
Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Maddoups

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)6. DATE OF BIRTH. May 2 1928
(Month) (Day) (Year)7. AGE Stillbirth
IF LESS than 1 day how many _____ hrs. or _____ min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Juniper Ida10. NAME OF FATHER Thomas Maddoups

11. BIRTHPLACE OF FATHER

(State or Country) Leviatown Utah12. MAIDEN NAME OF MOTHER Lorena Viola Hastings

13. BIRTHPLACE OF MOTHER

(State or Country) York Valley Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Tom Maddoups(Address) Juniper Ida15. Filed 6/3/28 J.M. Kerns
Local Registrar16. DATE OF DEATH May 9 1928
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 8 1928 to May 2 1928, that I last saw h. live alive on Still Birth 191 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)(Signed) Dr. J. H. Harkins M. D.19. (Address) Snowville Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Juniper Ida DATE OF BURIAL May 2 192820. UNDERTAKER Joe HarkinsADDRESS Snowville Utah

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers, who receive a definite salary*), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

214-72 037-265
RECEIVED JUN 12 1928
PLACE OF BIRTH

Form V. S. No. 11-C-25m-7-21-19

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 162303

County of Latah

City of Homedale

Registration District No. 130

File No. _____

No. _____ St. _____

Primary Registration District No. Homedale

Registered No. _____

Hospital _____

FULL NAME OF CHILD

Katie Ellen Saul

Sex of Child FM

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti
mate?

Date of
Birth

(To be answered only in event of plural births)

yes

May 12 1938
(Month) (Day) (Year)

FULL
NAME

FATHER

Wm R Saul

FULL
MAIDEN
NAME

MOTHER

Katie Sycraft

RESIDENCE

Homedale

RESIDENCE

Homedale

COLOR

W

AGE AT LAST
BIRTHDAY

22
(Years)

COLOR

W

AGE AT LAST
BIRTHDAY

18
(Years)

BIRTHPLACE

Ohio

BIRTHPLACE

Missouri

OCCUPATION

Farmer

OCCUPATION

HC

Number of child of this mother, including present birth 1

Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn, at 11.05a M. on the date above stated.

(Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Samuel Hopper

(Physician or midwife)

Given names added from a supplemental report.

Samuel Hopper 1938
R. Hopper
Registrar

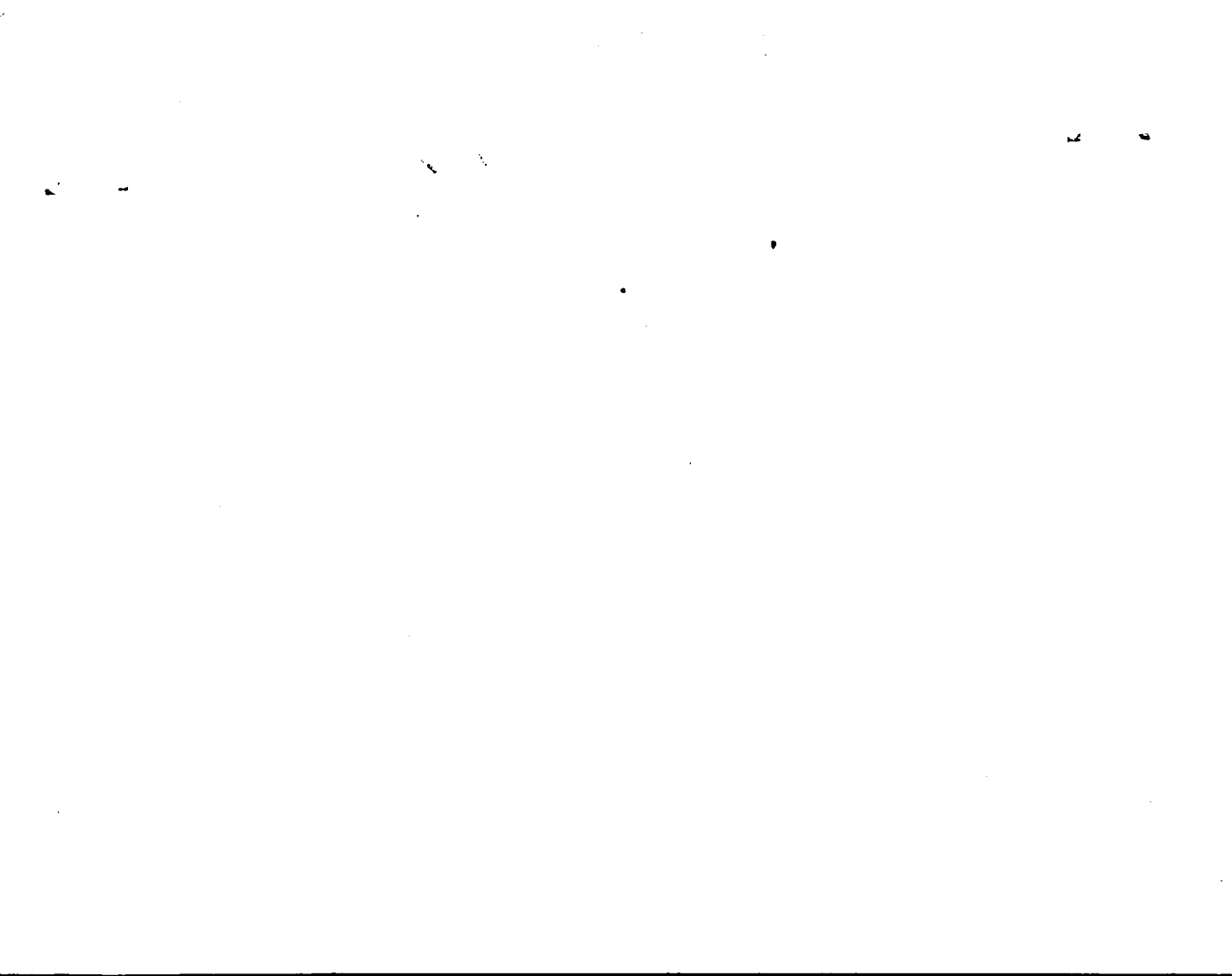
Address

Homedale

Filed

June 1 1938

S. Hopper
Registrar



RECEIVED JUN 12 1928

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boyer
City of Homedale

Registration District No. 130
Primary Registration District No. Homedale
(No. _____ St. _____)

File No. 61995

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Katie Ellen Saul

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FM 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH May 13 1928
(Month) (Day) (Year)

7. AGE 0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day
how many _____ hrs.
or 0 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER William R. Saul

11. BIRTHPLACE OF FATHER
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Katie Sweep

13. BIRTHPLACE OF MOTHER
(State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Bessie Sweep
(Address) Homedale

15. June 1 1928 S. Hopper
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 13 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1928, to May 13 1928, that I last saw him _____ alive on _____ 19____, and that death occurred on the date stated above, at 11:50 A.M.

The CAUSE OF DEATH was as follows:
Stillbirth
full term baby
Cause unknown

_____. (Duration) _____ Yrs. _____ mos. _____ ds.
Contributory _____
(Secondary) _____
_____. (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Simon Hopper M. D.
19 _____ (Address) Homedale

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Knowlton Heights DATE OF BURIAL May 13 1928

20. UNDERTAKER none ADDRESS _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 5 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Payette
City of Payette

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. 291-222-038-364 St.

Registration District No. 4 State File No. 162323

(If born in hospital or institution
give name.)

Prim. Registration District No. 1008 Local Registrar's No. 40

FULL NAME OF CHILD Bertha May Bias.

(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>May 22, 1928</u>
				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None.

Number of child of this mother, including present birth 9 (a) Born alive and now living 8

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME George Bias.

MOTHER
FULL MAIDEN NAME Frances Todd

Residence (Usual place of abode) Payette, Id.

Residence (Usual place of abode) Payette, Id.

If nonresident, give place and State -----

If nonresident, give place and State -----

Color or race White Age at last Birthday 42

Color or race White Age at last Birthday 42

Birthplace Tennessee (City and State or Country)

Birthplace Ohio (City and State or Country)

Occupation Laborer

Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9:00 a.m. M.
on the date above stated.

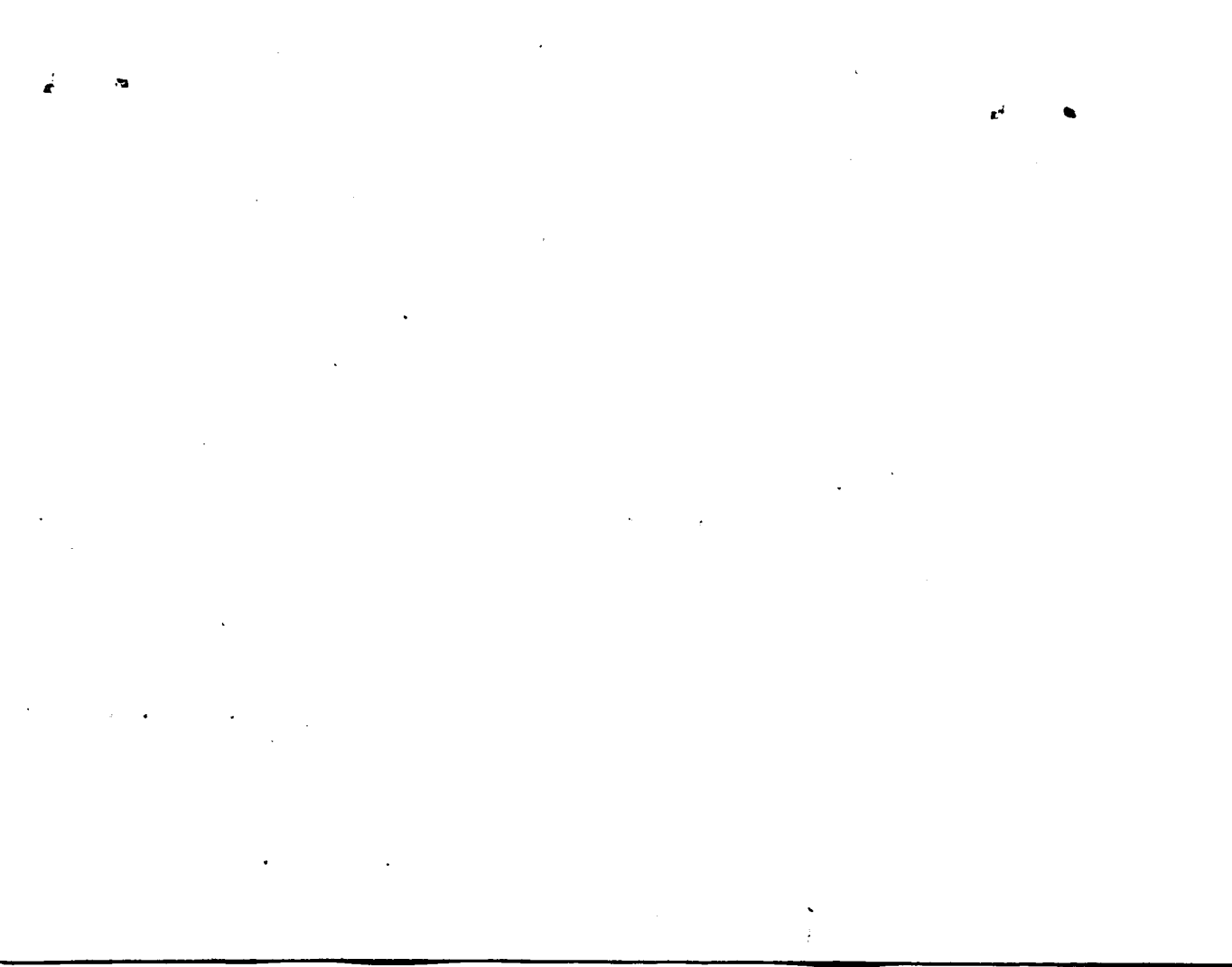
(Signature) J. C. Woodward Physician.

(Physician or midwife)

Address Payette, Idaho.

Filed May 31 1928 J. C. Woodward Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED JUN 1 1928
PLACE OF DEATH

DO NOT WRITE IN THIS SPACE

62001

State File No.

County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008

Local Registrar's No. 11

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)
2. FULL NAME Bertha May Bias
(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced, (write the word) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6. DATE OF BIRTH (month, day and year) May 22 - '28
7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, hrs. or min. _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Payette, Ida.
(State or country)

10. NAME OF FATHER Geo Bias

11. BIRTHPLACE OF FATHER (city or town) Ind.
(State or Country)

12. MAIDEN NAME OF MOTHER Francie Todd

13. BIRTHPLACE OF MOTHER (city or town) Tenn
(State or Country)

14. Informant Geo Bias
(Address) Payette, Ida.

15. Filed May 22, 1928 J.C. Woodward
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 22, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born infant. Cause of death unknown

_____, (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

_____, (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J.C. Woodward M. D.
5/22/28 19____ (Address) Payette, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal _____ Date of Burial _____

Payette, Ida. May 22, 1928

20. Undertaker _____ Address _____

Glen C. Landon Payette, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, "PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF RECEIVED JUN 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Laramie

City of Filer

No. 281-118 042-568 St. _____

Registration District No. 38

State File No. _____

Hospital _____

Primary Registration District No. 2086

Local Registrar's No. _____

FULL NAME OF CHILD

Gene Richard Shaff
(Certificate of no value without full name of child)

Sex of Child

Boy

Twin
Triplet
or other?
(To be answered only in event of plural births)

and

Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

May 18
(Month) (Day) (Year)

1928

What bactericidal solution was used in eyes?

Agno 1 to 10

Number of child of this mother, including present birth

4

Number of child of this mother now living, including present birth

3

FULL
NAME

FATHER

Chas. Shaff

RESIDENCE

Filer Ida

COLOR

W.

AGE AT LAST
BIRTHDAY

31
(Years)

BIRTHPLACE

Kas

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

Moh, Edna

RESIDENCE

Filer Ida

COLOR

W.

AGE AT LAST
BIRTHDAY

28
(Years)

BIRTHPLACE

Nebr.

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive { at 9:10 a M. on the date above stated. { Stillborn

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

Dr. A. G. Newberry

(Physician or midwife)

Address

5/18 S

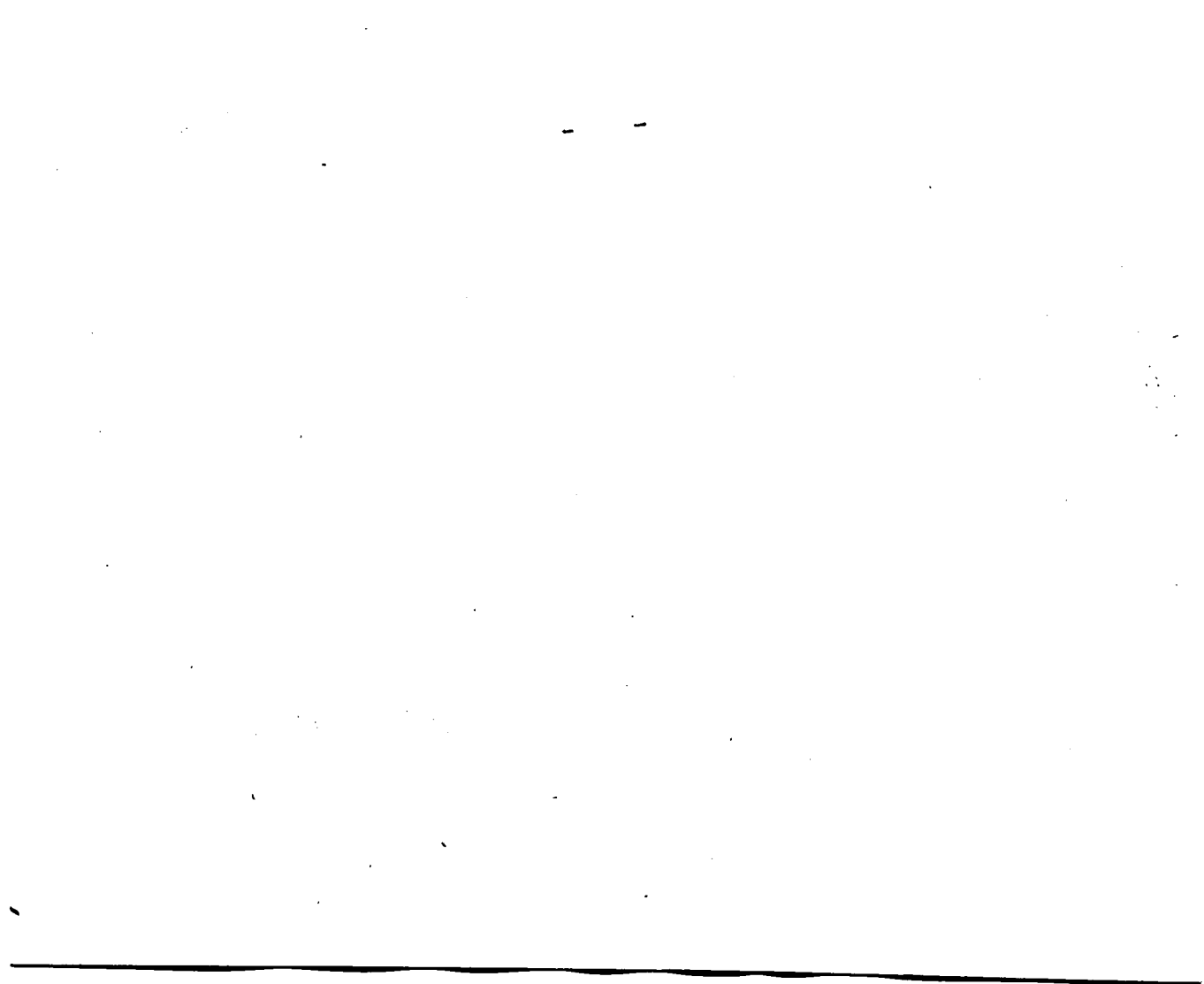
Filed

1928

Adm

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OR RECEIVED JUN 12 1928

STATE OF IDAHO

County of Lewin Falls Ida.

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S.

City of Lewin Falls

No. 494-104042963

CERTIFICATE OF BIRTH

162418

Lewin Falls Co. & Hn.

Registration District No. 37

State File No.

(If born in hospital or institution give name.)

Prim. Registration District No. 1031

Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>1</u> (To be answered only in event of plural births)	and { Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>May 4</u> (Month) (Day) (Year) <u>1928</u>
--------------------------	--	--	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 7

(a) Born alive and now living 7

Born alive but now dead

Stillborn 2

FATHER
FULL NAME John Lorenzo Middleton

Residence (Usual place of abode) Filer Ida.

If nonresident, give place and State

Color or race white Age at last Birthday 41 (Years)

Birthplace Penn.

(City and State or Country)

Occupation Carpenter

MOTHER
FULL MAIDEN NAME Grace Racale

Residence (Usual place of abode) Filer Ida.

If nonresident, give place and State

Color or race white Age at last Birthday 41 (Years)

Birthplace Birmingham Neb.

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was {
on the date above stated.

{
Stillborn
}

at

7:50 P. M.

(Signature)

A. A. McWherry
(Physician or midwife)

Address

Filer, Idaho

Filed

6/10 1928 N. T. Lett

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

162418

Registration District No. 17 State 15-10

Registration District No. 17 State 15-10

It certifies that the above named child was born at (city)

Legally
male?

Birth
date

Number of children (including stillborns)

Number of children of this mother (including present ones)

Full name

Father

Sex

Residence (usual place of abode)

If nonresident, give place and date

Color or race

Birthplace

Signature of attending physician or midwife

Signature of parent who was present at birth

(Signature)

(Signature of registrar)

Address

Where born
or place of birth
etc.
Date of birth
Name of mother
Name of father

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED MAY 12 1928
PLACE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **61562**

County of *Franklin*
City of *See Falls*

Registration District No. *37*
Primary Registration District No. *1085*

Local Registrar's No. *64*

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Infant Middleton*

(a) Residence. No. *See Falls* St.

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. Single, Married, Widowed, or Divorced (write word) *Infant*

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of *Infant*

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *0 0 0*
(b) General nature of industry, business, or establishment in which employed (or employer) *Infant*
(c) Name of employer

9. BIRTHPLACE (city or town) *See Falls Idaho* (State or country)

10. NAME OF FATHER *John Middleton*

11. BIRTHPLACE OF FATHER (city or town) *Idaho* (State or Country)

12. MAIDEN NAME OF MOTHER *Grace J. Long*

13. BIRTHPLACE OF MOTHER (city or town) *Idaho* (State or Country)

14. Informant *J. J. Middleton* (Address) *See Falls*

15. Filed *5/10*, 19 *28* *F. T. Lette* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 3* 19 *28*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at *8 PM* m. The CAUSE OF DEATH* was as follows:

Still Born
(Cause unknown)

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____ (Signed) *G. A. Newberry* M. D. *May 6*, 19 *28* (Address) *See Falls Idaho*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *See Falls Cemetery* Date of Burial *May 5* 19 *28*

20. Undertaker *J. C. Drake* Address *See Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home**. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None**.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably such**, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown**.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUN 12 1928

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S - 2
162429

County of Trim Falls
City of Trim Falls
No. 804-Karn St.
751-216 042-239
(If born in hospital or institution
give name.)

Registration District No. 37 State File No. 162429

Prim. Registration District No. 1085 Local Registrar's No. Shefferson

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>-</u>	and {	Number in order of birth <u>-</u>	Legiti- mate? <u>yes</u>	Date of birth <u>5-16-1928</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? -

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME James H. Peacher
Residence (Usual place of abode) Trim Falls
If nonresident, give place and State Ida
Color or race white Age at last Birthday 43
Birthplace Missouri (Years)
(City and State or Country)
Occupation Laborer

MOTHER
FULL MAIDEN NAME Rena Streeter
Residence (Usual place of abode) Trim Falls
If nonresident, give place and State Ida
Color or race white Age at last Birthday 28
Birthplace Mich (Years)
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 11:45 P M.
on the date above stated. { Stillborn }

(Signature) N. N. Leeto

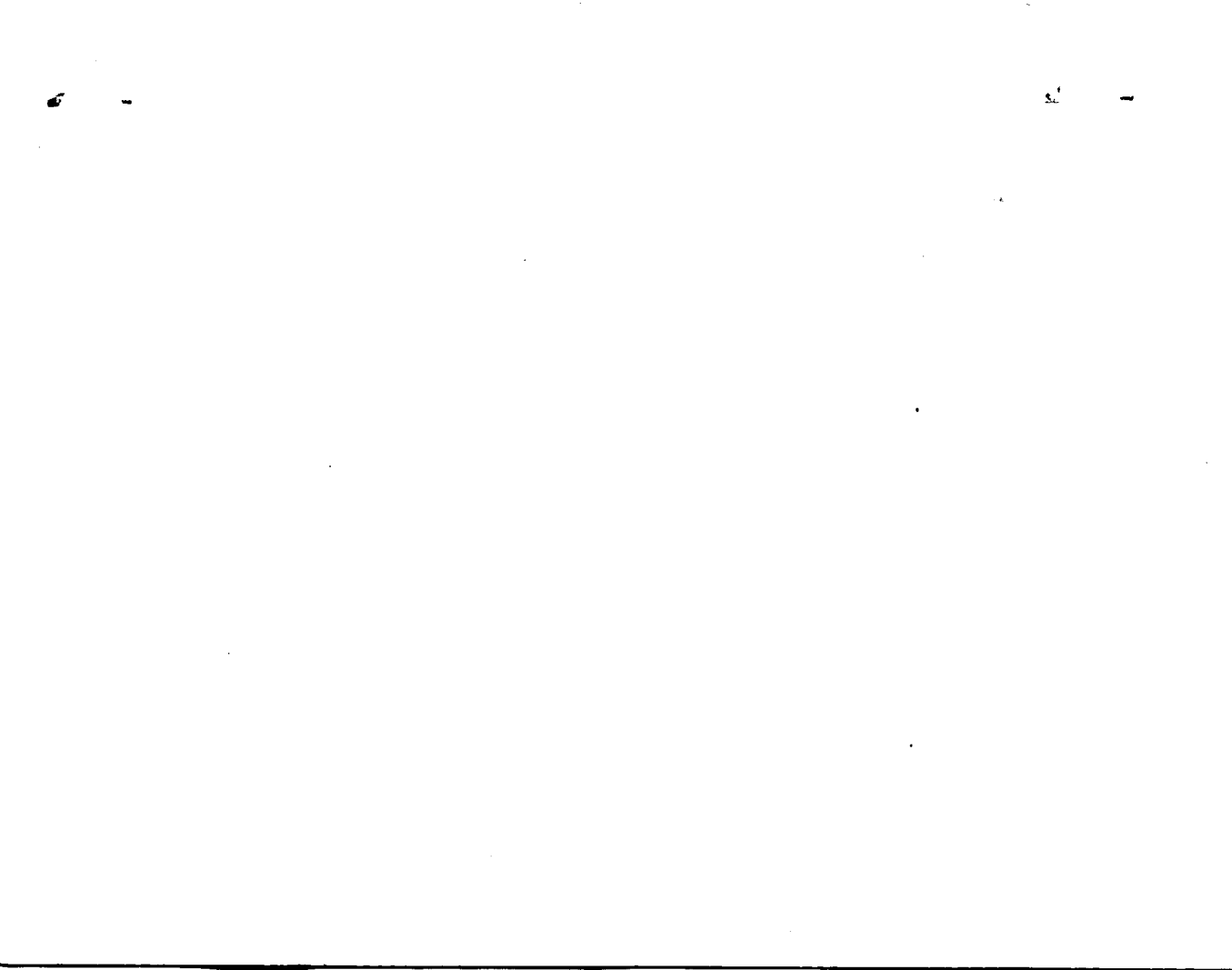
{ *Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth. }

(Physician or midwife)

Address Trim Falls Ida

Filed 6-10-1928 N. N. Leeto

Registrar.



RECEIVED JUN 12 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **62044**

PLACE OF DEATH

County of *Twin Falls*
City of *Twin Falls*

Registration District No. *37*Primary Registration District No. *1085*Local Registrar's No. *67*

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Baby Peacher*(a) Residence. No. *804 - 4th West* St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE *7* Years *#* Months *#* Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *none*(b) General nature of industry, business, or establishment in which employed (or employer) *-*(c) Name of employer *none*

9. BIRTHPLACE (city or town) *Town & Co. Id.*
(State or country)

10. NAME OF FATHER *James Peacher*

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) *Mo.*

12. MAIDEN NAME OF MOTHER *Rena Streeter*

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) *Mich.*

14. Informant *James Peacher*
(Address) *804 - 4th West*

15. Filed *5-10*, 19*28* *H. J. Lute*
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 18th 19*28*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5-16, 19*28*, to *5-16*, 19*28*

that I last saw her alive on *5-16-28*, 19*28*

and that death occurred, on the date stated above, at *10:45 a.m.*

The CAUSE OF DEATH* was as follows:

Still birth(duration) yrs. mos. ds. *0*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? *no* Date of *-*Was there an autopsy? *no*What test confirmed diagnosis? *exam*(Signed) *H. J. Lute*, M. D.*5-17*, 19*28* (Address) *Town & Co. Id.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Twin Falls *May 18 1928*

20. Undertaker *J. J. Grossman* Address *Twin Falls*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

17

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 11 1928
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S162475

County of Ada 814-116
City of Boise 001851
No. 1617 N. 24 St.

Salvation Army
(If born in hospital or institution give name.)

Registration District No. 2 State File No. 1004
Prim. Registration District No. 229 Local Registrar's No. 229

FULL NAME OF CHILD Virgil Le Roy Hamillott
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>no</u>	and Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>June 16</u> 19 <u>28</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? yes

Number of child of this mother, including present birth 6 (a) Born alive and now living 5
Born alive but now dead none Stillborn 1

FATHER
FULL NAME Lee B. Hamillott
Residence (Usual place of abode) Boise
If nonresident, give place and State Idaho
Color or race white Age at last Birthday 36 (Years)
Birthplace Minnesota
(City and State or Country)
Occupation Common Laborer

MOTHER
FULL MAIDEN NAME Inga Hval
Residence (Usual place of abode) Boise
If nonresident, give place and State Idaho
Color or race White Age at last Birthday 34 (Years)
Birthplace Omaha, Wisconsin
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 3:05 P. M. on the date above stated.

(Signature) Sutton M. A.
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Boise, Idaho
Filed 6-26 1928 Tulla M. Donald
Registrar.

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX AND TILDEN FOUNDATIONS
455 FIFTH AVENUE
NEW YORK 17, N. Y.

TYPE: 10430

STATE OF IDAHO
DEPT. OF PUBLIC WORKS
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

072510

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW

CONFIDENTIAL 1137

bliss

1944

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. **62105**

County of **Ada.**
City of **Boise.**

Registration District No. **2**
Primary Registration District No. **1004**

Local Registrar's No. **161**

(No. **Salvation Army Rescue Home.**)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Baby Hamilton.**

(a) Residence. No. **Boise, Idaho.** St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male.** 4. COLOR OR RACE **White.** 5. Single, Married, Widowed, or Divorced (write the word) **Single.**

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6. DATE OF BIRTH (month, day and year) **June 16th 1928.**

7. AGE Years Months Days If LESS than 1 day, min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **None.**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **Boise, Idaho.**
(State or country)

10. NAME OF FATHER **Lee Hamilton.**

11. BIRTHPLACE OF FATHER (city or town) **Minnesota.**
(State or Country)

12. MAIDEN NAME OF MOTHER **Inga Vahn.**

13. BIRTHPLACE OF MOTHER (city or town) **Wis.**
(State or Country)

14. Informant **Pearl Allen.**

(Address) **Boise, Idaho.**

15. Filed **6-18-28** **Karl M. Donato**
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **June 16th 1928.**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **6/16/28** to **6/16/28**, 19**28**
that I last saw **him** alive on **6-16**, 19**28**
and that death occurred, on the date stated above, at **3:30 P.** m.
The CAUSE OF DEATH* was as follows:

Still born.

CONTRIBUTORY (Secondary)

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) **Carl M. Donato**, M. D.
6/18/28, 19**28** (Address) **Boise, Idaho.**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal **County Cemetery.** Date of Burial **6/18/28** 19**28**

20. Undertaker **Wm. McBratney.** Address **Boise, Ida.**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF RECEIVED JUL 11 1928

STATE OF IDAHO

County of Ada 669-107
City of Boise 001 '69/
No. St. Alphonsus Hospital
743 E. Jeff
(If born in hospital or institution
give name.)

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

R
S162499

Registration District No. 2 State File No. _____

Prim. Registration District No. 100 Local Registrar's No. 205

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>June 7</u> 19 <u>28</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn Stillborn

FATHER FULL NAME <u>Albert Glenn Forman</u>	MOTHER FULL MAIDEN NAME <u>Martha Rebella Wray</u>
--	---

Residence (Usual place of abode) Boise Residence (Usual place of abode) Boise

If nonresident, give place and State Ida If nonresident, give place and State Ida

Color or race w Age at last Birthday 39 Color or race w Age at last Birthday 39
(Years) (Years)

Birthplace Utah Birthplace Idaho
(City and State or Country) (City and State or Country)

Occupation Salismen Occupation HW

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:30 P.M.
on the date above stated.

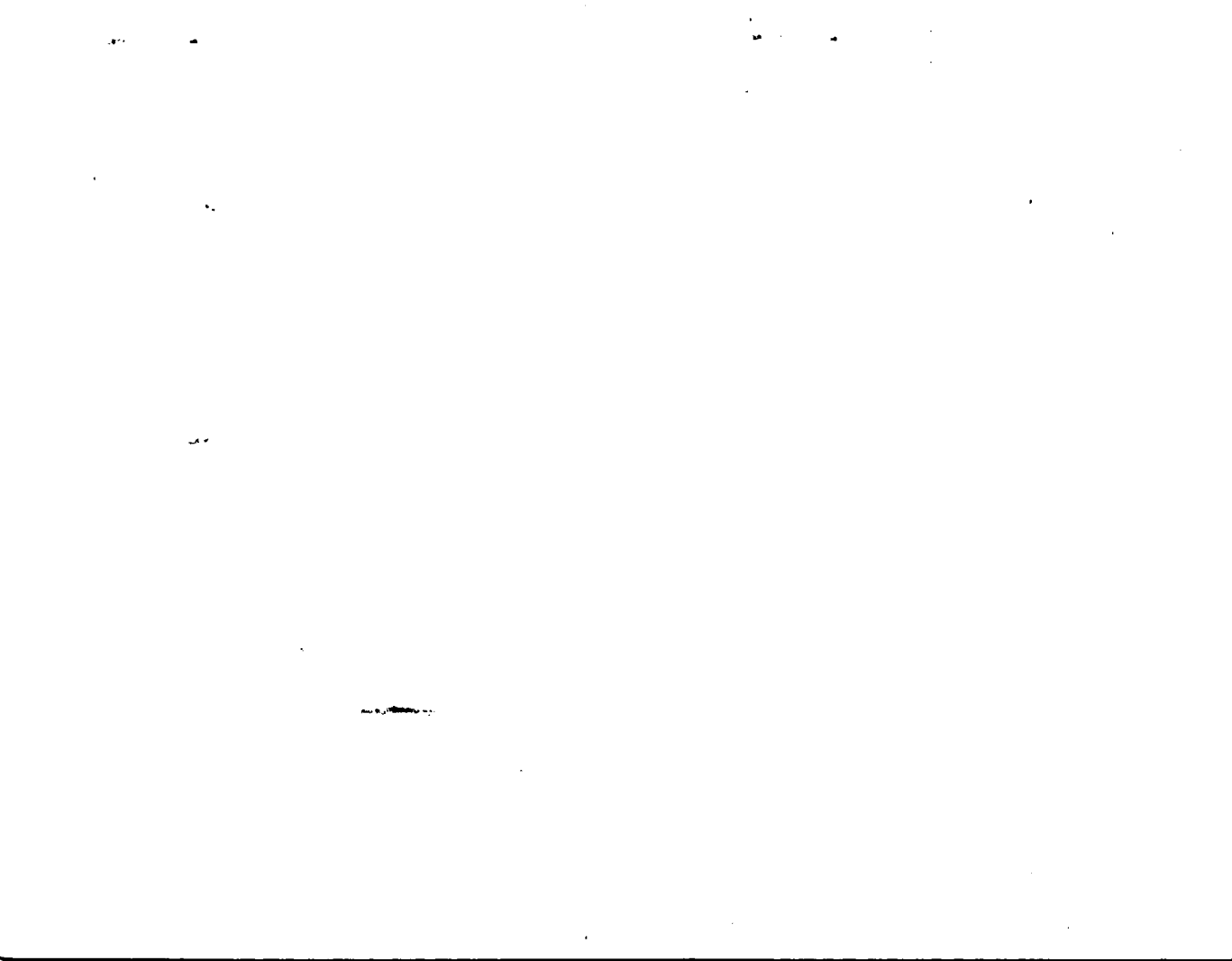
(Signature) Ann Bork

(Physician or midwife)

Address Boise Ida

Filed 6/18/28 1928 Paula M. Moran
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 2093

PLACE OF DEATH
County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital.)

Local Registrar's No. 174

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Forman.(a) Residence. No. Boise, Idaho. St.(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male. 4. COLOR OR RACE White. 5. Single, Married, Widowed, or Divorced (write the word) Single.

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 7th 1928.

7. AGE Years Months Days If LESS than 1 day,
0 0 0 ----- min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

10. NAME OF FATHER Albert G. Forman.

11. BIRTHPLACE OF FATHER (city or town) Heber, Utah.
(State or Country)

12. MAIDEN NAME OF MOTHER Martha Wray.

13. BIRTHPLACE OF MOTHER (city or town) Moreland, Idaho.
(State or Country)

14. Informant Albert G. Forman.
(Address) Boise, Idaho.

15. Filed 6/9/28, 19 28 Paula M. Donald
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 7th 1928.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7th 1928 to June 7th 1928
that I last saw him alive on June 7th 1928
and that death occurred, on the date stated above, at ----- m.

The CAUSE OF DEATH* was as follows:

foetus was a moulting foetus -
1 1/2 hrs. only - no brain - and
otherwise deformed

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Bank, M. D.
6/8/28, 19 28 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Moreland, Idaho. Date of Burial 6/9/28 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. All diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Ida
City of Kuna

No. 957-128 001 152 St.

(If born in hospital or institution give name.)

Registration District No. _____ State File No. 162526

Prim. Registration District No. _____ Local Registrar's No. 55

FULL NAME OF CHILD Rexroad

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>5 - 28 1928</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? no

Number of child of this mother, including present birth 7 (a) Born alive and now living 6

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Harry A. Rexroad
Residence (Usual place of abode) Kuna, Ida

If nonresident, give place and State _____

Color or race white Age at last Birthday 33 (Years)

Birthplace Kansas
(City and State or Country)

Occupation Farming

MOTHER
FULL MAIDEN NAME Grace Jessesee
Residence (Usual place of abode) Kuna, Ida

If nonresident, give place and State _____

Color or race white Age at last Birthday 36 (Years)

Birthplace Bern Co. Idaho
(City and State or Country)

Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive on the date above stated. 7-A M.

Premature (Signature) F. Coleman

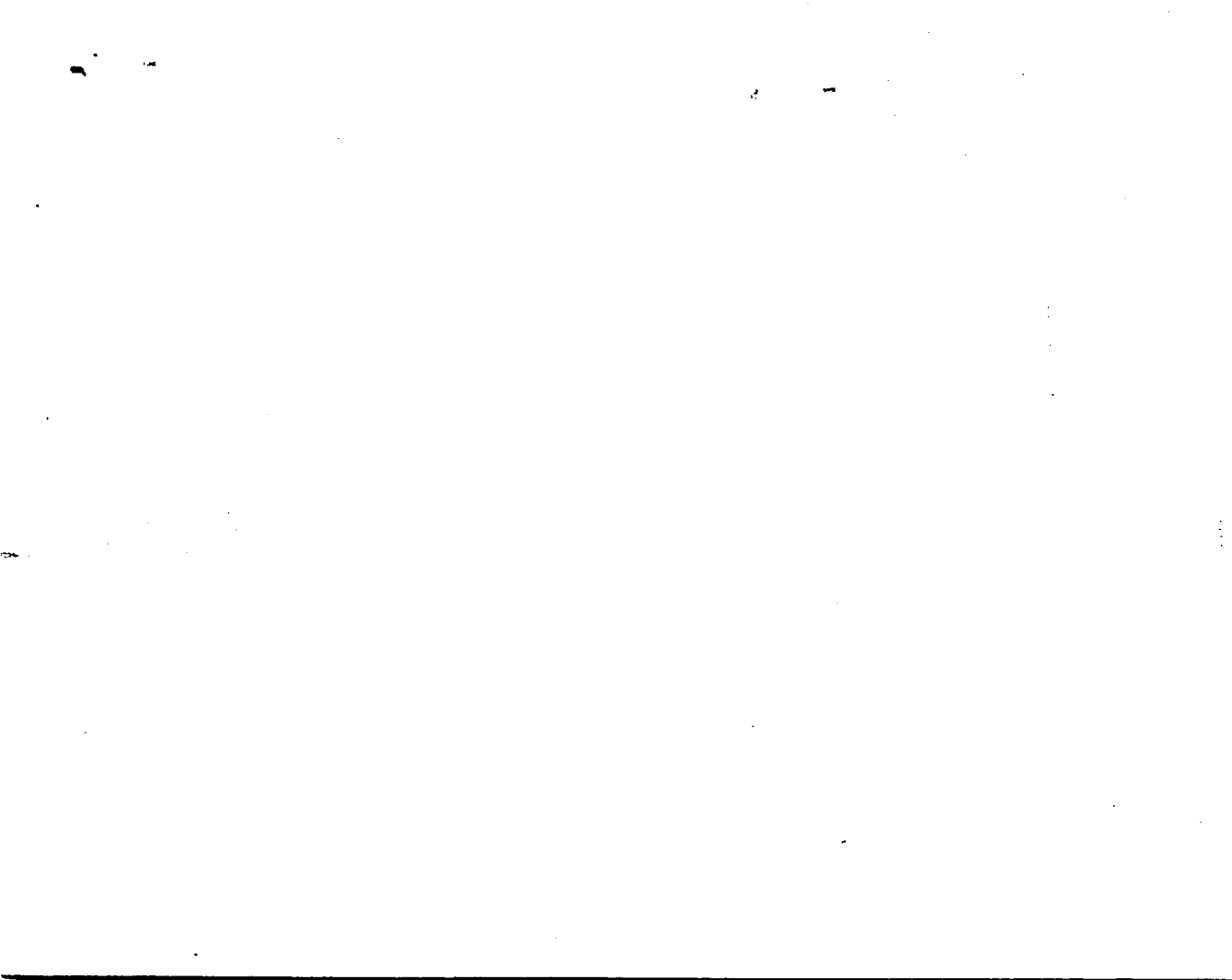
*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Kuna, Idaho

Address _____

Filed 6-2 1928 Roy Musseman

Registrar.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 3 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 62120

Local Registrar's No. 189

PLACE OF DEATH
County of Ada
City of Kuna

Registration District No.

Primary Registration District No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Reese

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE

Years

Months

Days

Premature & Stillborn1 If LESS than
day, hrs.
or min.

8 OCCUPATION OF DECEASED

born

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Kuna, Ida

10 NAME OF FATHER

Harry A. Rexroad

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Kansas

12 MAIDEN NAME OF MOTHER

Grace Lessee

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Gen Co.

14 Informant (Address)

Harry A. Rexroad
Kuna Ida

15 Filled

6-2

1928

Ray M. Sulman
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

5
(Month)28
(Day)28
(Year)

17 I HEREBY CERTIFY, That I attended deceased from
_____, 19_____, to _____, 19_____,
that I last saw him alive on _____, 19_____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Premature and Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

5-28

1928

(Address)

Kuna Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Kuna Ida

Date of Burial

5-28 1928

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

JUL 3

1928

STATE OF IDAHO

County of Bannock

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of Lava Hot Spring

CERTIFICATE OF BIRTH

S-162579

No. 289-222003-864

St.

Registration District No. 84

State File No.

(If born in hospital or institution give name.)

Prim. Registration District No. 2161 Local Registrar's No. 536

FULL NAME OF CHILD Verla Byington

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female

Twin
Triplet
or other?

Twins and

Number
in order
of birth

1

Legiti-
mate? yes

Date of
birth

June 22

1928

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 4

(a) Born alive and now living 2

Born alive but now dead 2

Stillborn 2

FULL
NAME

FATHER

Roy Lovel Byington

FULL
MAIDEN
NAME

MOTHER

Florence Wanda Housley

Residence (Usual place of abode) Lava Hot Spring

Residence (Usual place of abode) Lava Hot Spring

If nonresident, give place and State

If nonresident, give place and State

Color or race White

Age at last Birthday 36

(Years)

Color or race White

Age at last Birthday 28

(Years)

Birthplace Menan Idaho

(City and State or Country)

Birthplace Hiwassee Utah

(City and State or Country)

Occupation Fideler

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

Born alive
Stillborn

at

10:30 P.

M.

(Signature) A. Rich

(Physician or midwife)

Address Lava Hot Spring Ida

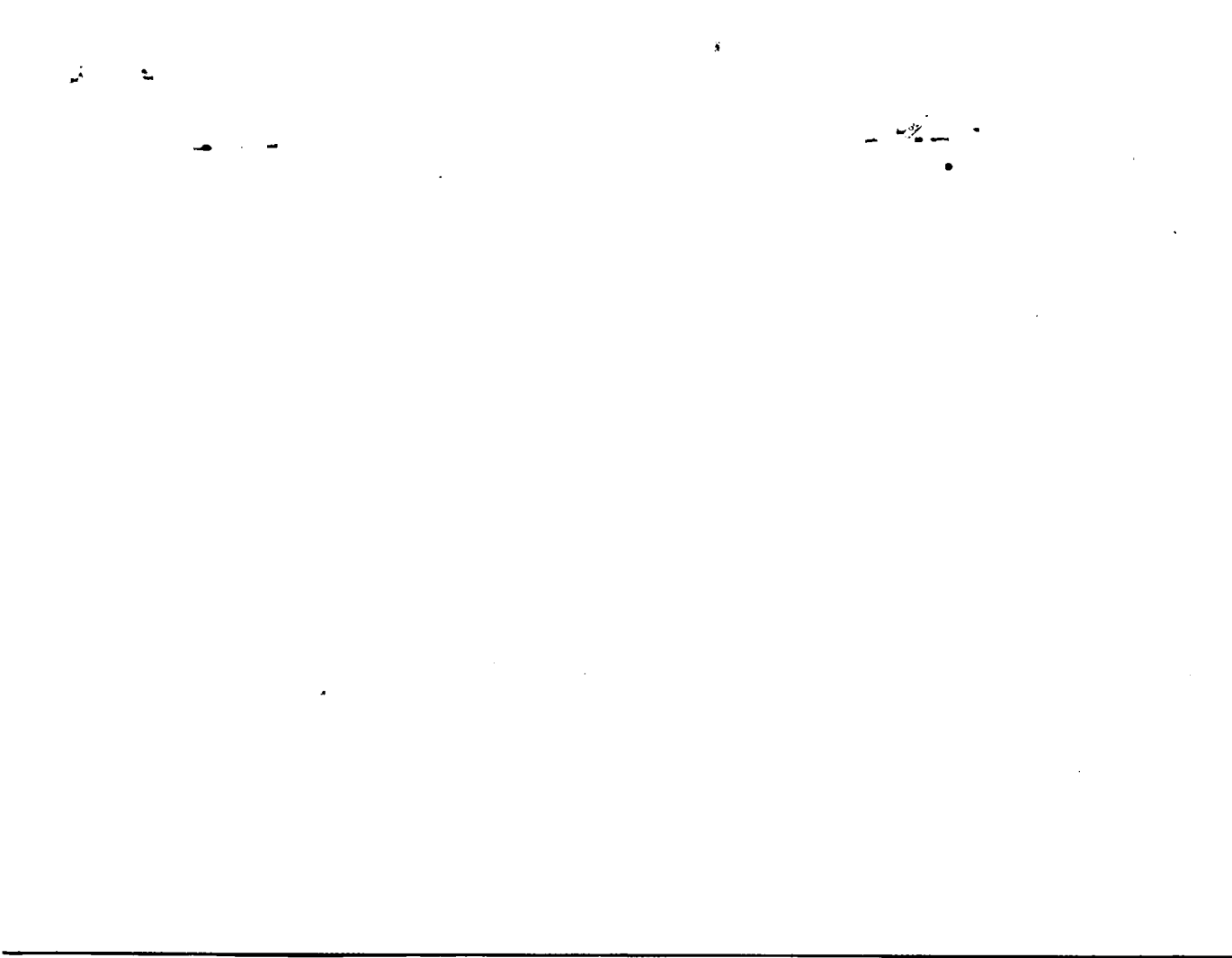
Filed 6/30

1928

Wm. G. Felt

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 3 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 62130Local Registrar's No. 126

PLACE OF DEATH

County of CannockRegistration District No. 84City of Lava Hot SpringsPrimary Registration District No. 2161

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Verla Byington

(a) Residence. No. _____

St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 22-1928

7 AGE Years Months Days If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lava Hot Springs
(State or country) Idaho10 NAME OF FATHER Roy Lovel Byington11 BIRTHPLACE OF FATHER (city or town) Menan Idaho
(State or country)12 MAIDEN NAME OF MOTHER Flora Wanda Housley13 BIRTHPLACE OF MOTHER (city or town) Hiram Utah
(State or country)14 Informant C. A. Rich M.D. (copy from Birth City)
(Address) Lava Hot Springs, Ida.15 Filed 6-30, 1928 Mrs. G. E. Tit
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 22 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1928, to June 22, 1928.
never saw that I last saw her alive on any time, 19____,
and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH was as follows:

Premature Delivery
@ 7mo. Gestation

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Unknown
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.
18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of _____Was there an autopsy? NoWhat test confirmed diagnosis? None

(Signed) C. A. Rich M. D.
6-23-28, 1928 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal _____ Date of Burial
19

20. Undertaker _____ Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH Bannock JUL 3 1928 STATE OF IDAHO
County of Bannock DEPARTMENT OF PUBLIC WELFARE
City of Lava Hot Springs BUREAU OF VITAL STATISTICS
No. 291-222-003-864 St. 84 CERTIFICATE OF BIRTH **S**
Registration District No. 84 State File No. 162580
(If born in hospital or institution give name.) Prim. Registration District No. 2161 Local Registrar's No. 537

FULL NAME OF CHILD Verna Byington
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin <u>Yes</u> Triplet <u>No</u> or other <u>No</u> (To be answered only in event of plural births)	and { Number in order of birth <u>2nd</u> }	Legitimate? <u>Yes</u>	Date of birth <u>June 22</u> 1928 (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 5 (a) Born alive and now living 2
Born alive but now dead 3 Stillborn 3

FATHER FULL NAME <u>Roy Lovel Byington</u>	MOTHER FULL MAIDEN NAME <u>Florence Manda Housley</u>
---	--

Residence (Usual place of abode) Lava Hot Springs

If nonresident, give place and State

Color or race White Age at last Birthday 36 (Years)

Birthplace Menan Idaho (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 11 P M.
on the date above stated. { Stillborn }

(Signature) R. A. Kich

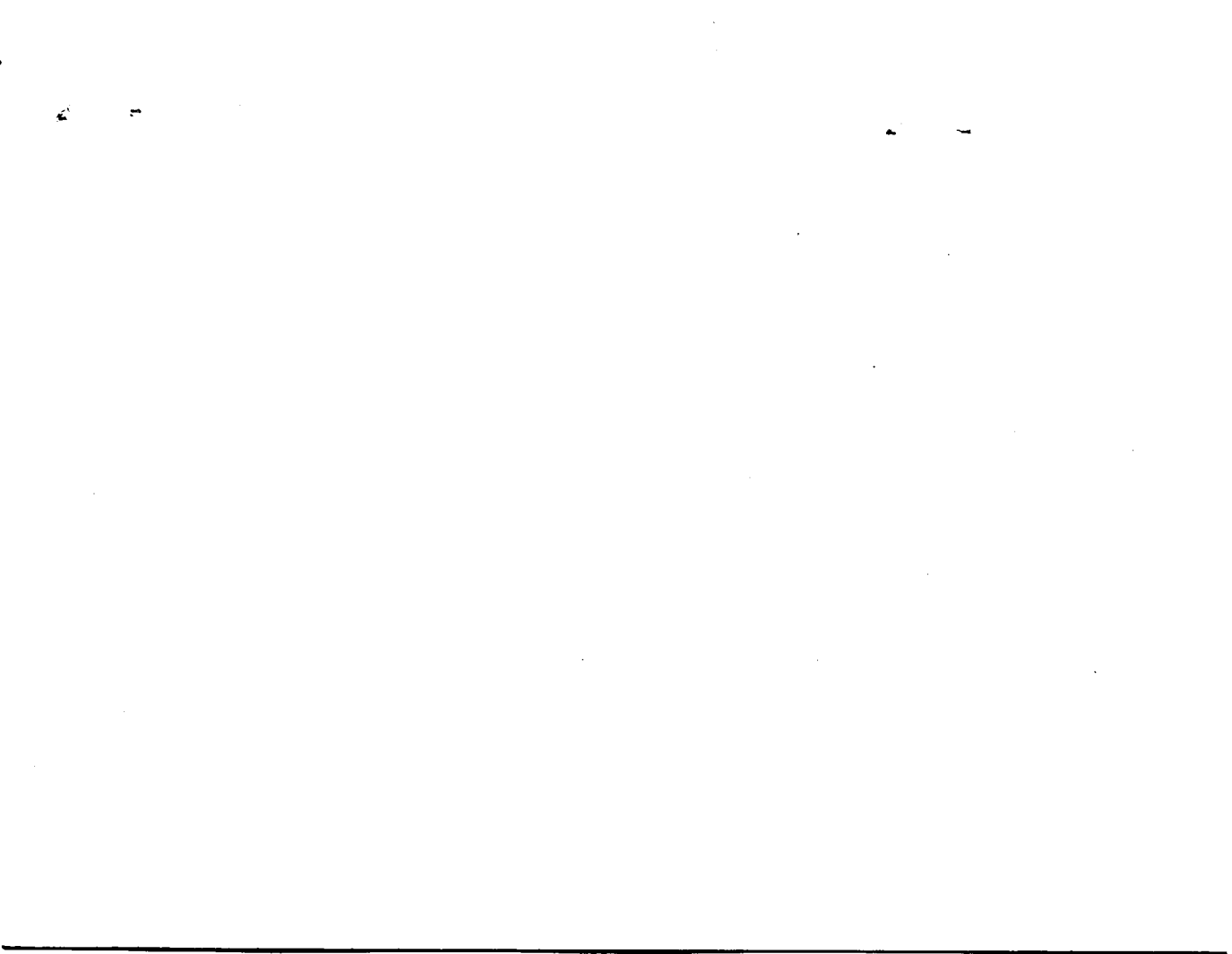
M.D.
(Physician or midwife)

Address Lava Hot Springs

Filed 6-30-1928 Mrs. C. J. Fitz

Registrar 3

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 3 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 62129

Local Registrar's No. 125

County of Cannock Registration District No. 84
City of Lava Hot Spring Primary Registration District No. 2161

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Verna Byington

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 22, 1928

7 AGE Years _____ Months _____ Days _____
1 day, _____ hrs. _____ min. LESS than

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lava Hot Springs
(State or country) Idaho

10 NAME OF FATHER Roy Lovel Byington

11 BIRTHPLACE OF FATHER (city or town) Menan
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Florence Wanda Housley

13 BIRTHPLACE OF MOTHER (city or town) Hiram
(State or country) Utah

14 Informant C. A. Rich (Copy from Birth cert.)
(Address) Lava Hot Springs

15 Filled 6-30- 1928 Mrs. J. G. Telford
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 22 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1928, to June 22, 1928.
that I ~~last~~ never saw her alive on any time, 1928,
and that death occurred, on the date stated above, at 11:30 p. m.

The CAUSE OF DEATH* was as follows:

Premature delivery
@ 7 mo. gestation

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Unknown
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no. Date of _____

Was there an autopsy? no.

What test confirmed diagnosis? None

(Signed) C. A. Rich, M. D.

6-23- 1928 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal _____ Date of Burial _____
19

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bear Lake
City of Fish Haven
No. _____ St. _____

469-12004-168

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Registration District No. 55 State File 162587

Prim. Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin } Triplet } or other? } (To be answered only in event of plural births)	and {	Number } in order } of birth }	Legiti- } mately }	Date of birth <u>June 20</u> 19 <u>28</u> (Month) (Day) (Year)
--------------------------	---	-------	--------------------------------------	-----------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Melvin Mortensen

Residence (Usual place of abode) Fish Haven

If nonresident, give place and State _____

Color or race White Age at last Birthday 30
(Years)

Birthplace Idaho
(City and State or Country)

Occupation farmer

MOTHER
FULL MAIDEN NAME J. Elmina Johnston

Residence (Usual place of abode) Fish Haven

If nonresident, give place and State _____

Color or race White Age at last Birthday 32
(Years)

Birthplace Idaho
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Premature { Stillborn } at 9 P M.
on the date above stated.

7 1/2 mrs. due to acute nephritis (Signature) Dr. Moore M D
Paris Idaho
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address _____

Filed June 21 1928 Hannah J. Kels on
Registrar.

Shog

PLACE OF BIRTH JUL 5 1928

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11—25m-6-18-1

County of Benewah
692 206 095 151
City of Deer Lake

No. _____ St. _____

Registration District No. 91

File No. S162622

Hospital _____

Primary Registration District No. _____

Registered No. 7

Full Name of Child Julia Margaret Wieshtausen

SEX OF CHILD <u>F</u>	Twin Triplet or other? <u>—</u> and { Number in order of birth <u>—</u>	Legitimate? <u>yes</u>	DATE OF BIRTH <u>June 6 1928</u> (Month) (Day) (Year)
FULL NAME <u>John Wieshtausen</u>	FATHER	FULL MAIDEN NAME <u>Anna Augusta</u>	MOTHER
RESIDENCE <u>Edward Allen Benewah</u>		RESIDENCE <u>Benewah</u>	
COLOR <u>Indian</u> AGE AT LAST BIRTHDAY <u>24</u> (Years)		COLOR <u>Indian</u> AGE AT LAST BIRTHDAY <u>19</u> (Years)	
BIRTHPLACE <u>Benewah Benewah</u>		BIRTHPLACE <u>Benewah</u>	
OCCUPATION <u>Laborn</u>		OCCUPATION <u>Wife</u>	

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Still Born at 49 on the date above stated.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. A. Nelson

Given names added from a supplemental report.

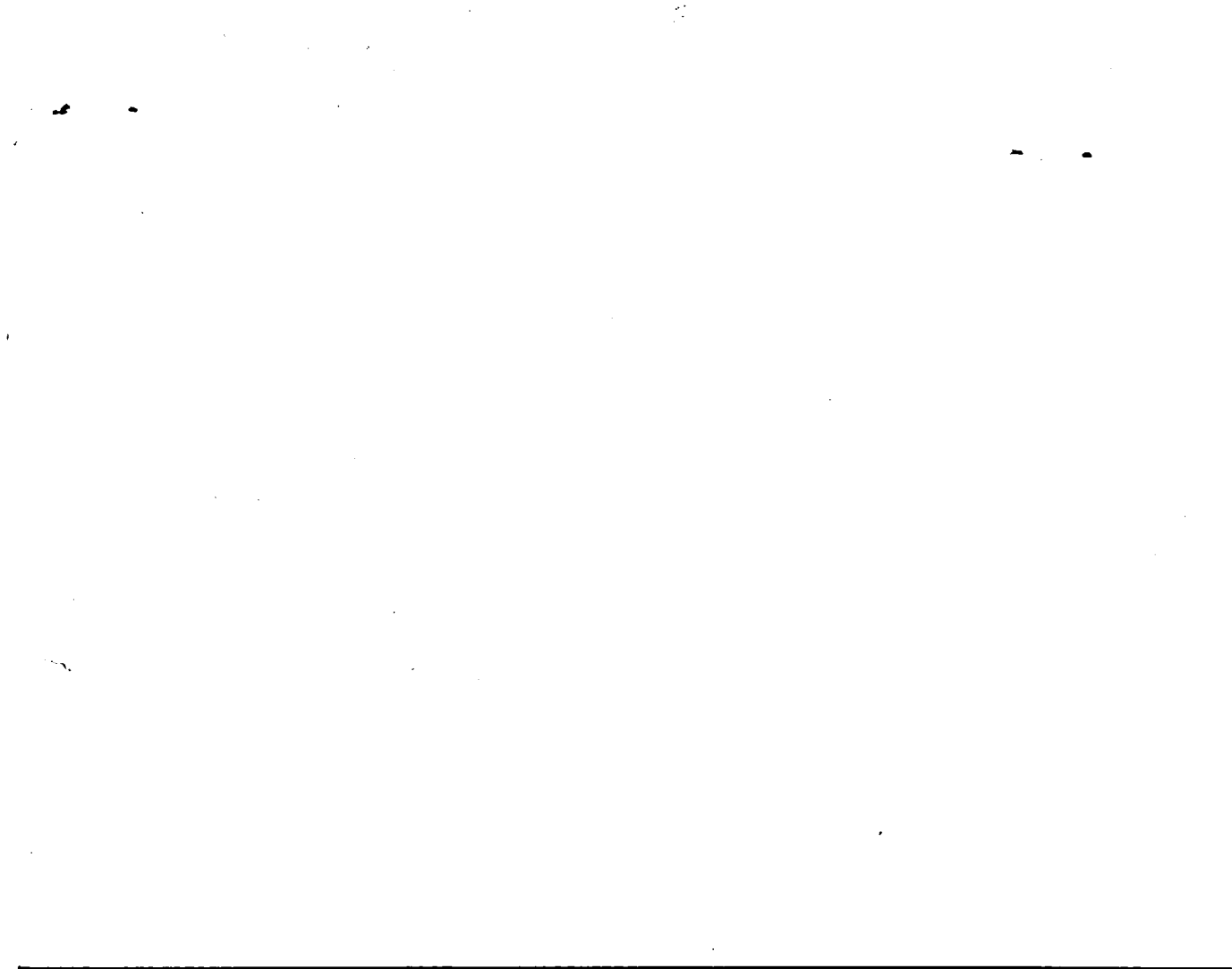
(Physician or midwife)

Address Benewah

Filed June 6 1928

Registrar

Registrar



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

62140

1 PLACE OF DEATH

County

State

Registered No.

Township

or Village

City

No.

St.,

or

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

(a) Residence. No.

St.,

Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed June 6, 1928

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY that I attended deceased from

June 6, 1928, to June 6, 1928,

that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn,
Prolapse of cord.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. Nelson, M. D.

46 1928 Address Des Moines

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Des Moines, Ida. June 7, 1928

20 UNDERTAKER

ADDRESS

None

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or marriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undecipherable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

11—3184

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

759 122-009-255
PLACE OF BIRTH

County of San Francisco
City of San Francisco
No. St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S
162681

CERTIFICATE OF BIRTH
Registration District No. 76 State File No.
Prim. Registration District No. 2155 Local Registrar's No.

(If born in hospital or institution give name.)

FULL NAME OF CHILD
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>6 22 1925</u> (Month) (Day) (Year)
--------------------------	---	---	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living
Born alive but now dead Stillborn Yes

FATHER
FULL NAME Arthur H. St. Germain
Residence (Usual place of abode) Labrie, Idaho
If nonresident, give place and State
Color or race White Age at last Birthday 35 (Years)
Birthplace Osburn, Idaho
(City and State or Country)
Occupation Tramcar

MOTHER
FULL MAIDEN NAME Eunice Kensing
Residence (Usual place of abode) Labrie, Idaho
If nonresident, give place and State
Color or race White Age at last Birthday 36 (Years)
Birthplace Idaho
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 1 M.
on the date above stated.
(Signature) W. C. Alcorn, M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address San Francisco, Idaho
Filed July 3 1925 Viola Allen
Deputy Registrar.

100

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

814-225-235

PLACE OF RECEIVED JUL 3 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of Bonneville
City of Idaho Falls, Idaho.

No. Memorial Drive St.
L. D. S. Hospital.

(If born in hospital or institution
give name.)

Registration District No. 73 State File No. 162702

Prim. Registration District No. 14-0 Local Registrar's No. 349

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin Triplet or other? <u>---</u>	and <u>Number</u> in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>May 25, 1928</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Neo-Silver 20%

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead --- Stillborn ---

FATHER
FULL NAME Leonard B. Hammer,

Residence (Usual place of abode) Idaho Falls, Ida.

If nonresident, give place and State ---

Color or race White Age at last Birthday 28

(Years)

Birthplace Woodville, Idaho.

(City and State or Country)

Occupation Farmer

MOTHER
FULL MAIDEN NAME Delsa Stewart,

Residence (Usual place of abode) Idaho Falls, Ida.

If nonresident, give place and State ---

Color or race White Age at last Birthday 22

(Years)

Birthplace Croydon, Utah.

(City and State or Country)

Occupation Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was (Born alive) Stillborn at M 9:40 A.M.
on the date above stated.

(Signature) [Signature]

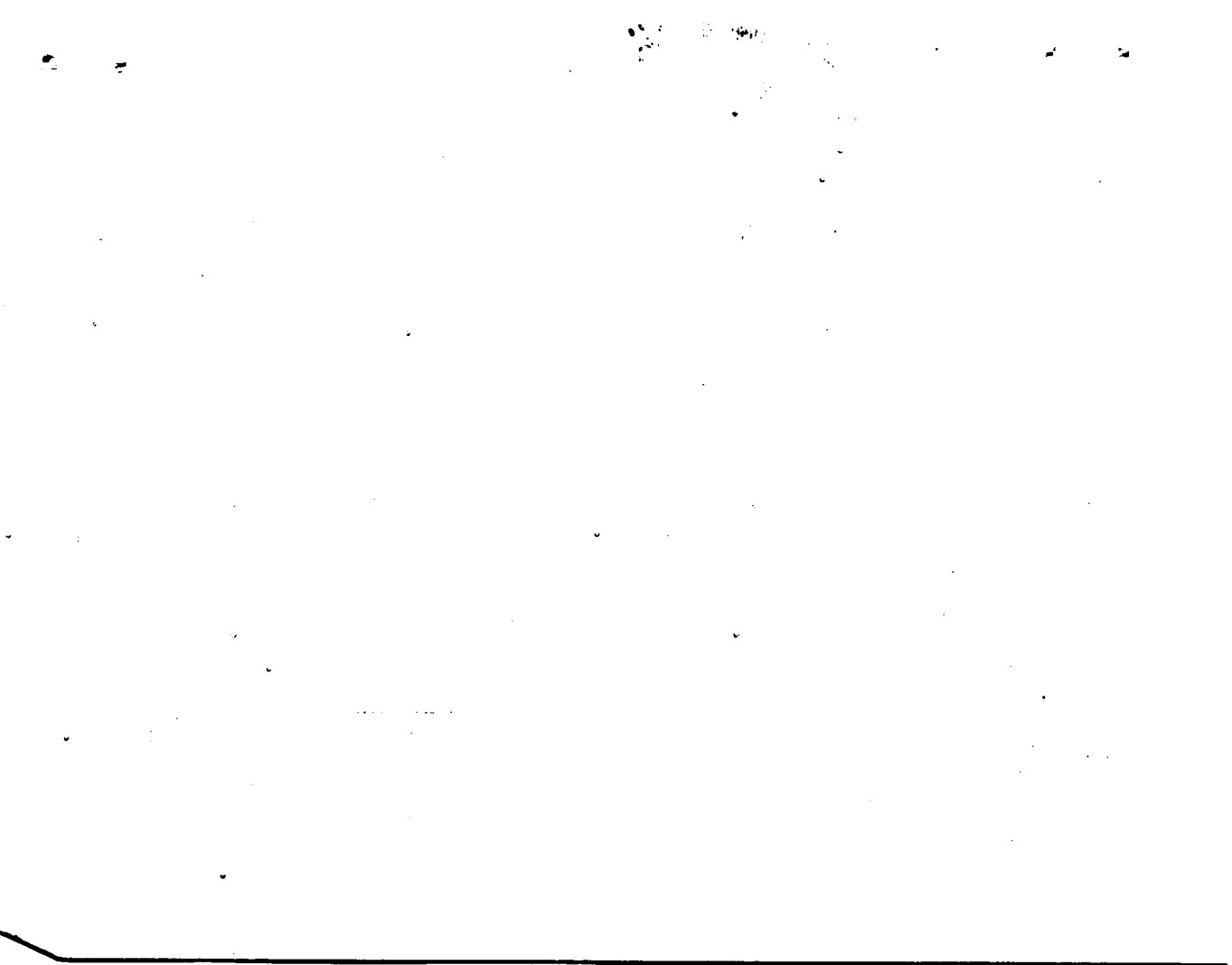
(Physician or midwife)

Address Idaho Falls, Idaho.

Filed --- 19 ---

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 12 1928

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 13
Primary Registration District No. 214

DO NOT WRITE IN THIS SPACE

State File No. 61796Local Registrar's No. 41

(If death occurred in a hospital or institution, give its name instead of street and number.)
2. FULL NAME Still born

(a) Residence. No. Idaho Falls R. #7 St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Baby

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Still birth

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day _____ hrs. _____ or _____ min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Idaho Falls, Ida.
(State or country)10 NAME OF FATHER Leonard B. Hammer11 BIRTHPLACE OF FATHER (city or town) Goodville Idaho
(State or country)12 MAIDEN NAME OF MOTHER Orlisa Stewart13 BIRTHPLACE OF MOTHER (city or town) Croyden
(State or country)

14 Informant father Leonard B. Hammer
(Address) City R. #7

15 Filed May 25, 19 28 C. J. Hammond
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 25 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1928, to May 25, 1928, that I last saw him alive on May 25, 1928, and that death occurred, on the date stated above, at Still birth m. 9:40 am.

The CAUSE OF DEATH* was as follows:

① Purpura Examinia of mother & Eclampsia.
② Premature Birth 7 months
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Ch. Hypertension
(Secondary) mother
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted Idaho Falls, Ida.
if not at place of death? in mother

Did an operation precede death? yes Date of 9/24/28
Was there an autopsy? no Induced labor

What test confirmed diagnosis? Dr. M. D.
(Signed) 1/25, 19 28 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Cremation Date of Burial 19
20. Undertaker Ullman Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JUL 3 1928

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

162707

County of Bannock
City of Idaho Falls
No. 451716210-355 St.

Registration District No. 73 State File No. 162707
Prim. Registration District No. 21170 Local Registrar's No. 343

(If born in hospital or institution give name.)

FULL NAME OF CHILD Deardon, Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate? <u>ye</u>	Date of birth <u>June 16 1928</u> (Month) (Day) (Year)
--------------------------	------------------------------	-----	--------------------------------	----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Deardon, Peter

MOTHER
FULL MAIDEN NAME Lee, Lillian

Residence (Usual place of abode) Payson, Idaho

Residence (Usual place of abode) Payson, Idaho

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race white Age at last Birthday 37
(Years)

Color or race white Age at last Birthday 22
(Years)

Birthplace Idaho
(City and State or Country)

Birthplace Idaho
(City and State or Country)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 12:05 A. M. on the date above stated.

(Signature) H. H. Miller M. D.

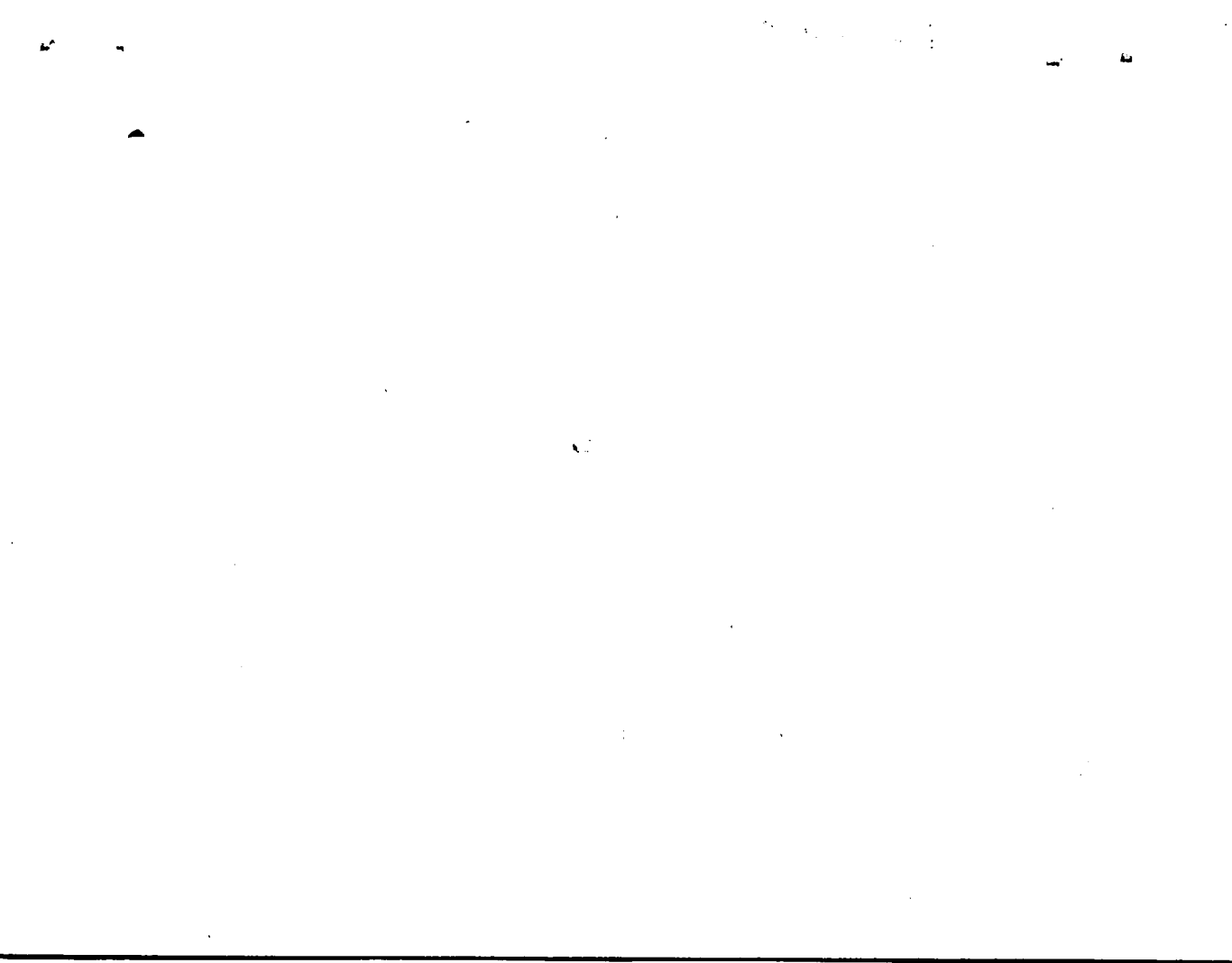
(Physician or midwife)

Address Idaho Falls, Idaho

Filed 6/20 19 28 Continued

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JUL 3 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 62179

PLACE OF DEATH

County of BonanzaCity of Idaho FallsRegistration District No. 73Primary Registration District No. 211-3(No. Go. H. S. Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1002. FULL NAME Infant Morgan(a) Residence. No. 308 S. Street St.

(Usual place of abode)

Length of residence in city or town where death occurred. 1 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? 1 yrs. 0 mos. 0 ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX

male

4. COLOR OR RACE

white

5. Single, Married, Widowed, or Divorced (write the word)

Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of =6. DATE OF BIRTH (month, day and year) 6/16/25

7. AGE

Years

Months

Days

LESS than 1 day, Stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls
(State or country) Ida.10. NAME OF FATHER L. C. Morgan11. BIRTHPLACE OF FATHER (city or town) Morgan Utah
(State or Country)12. MAIDEN NAME OF MOTHER William Lees13. BIRTHPLACE OF MOTHER (city or town) Kennamer Wyo.
(State or Country)14. Informant L. C. Morgan(Address) 308 S. St. Idaho Falls15. Filed 6/20, 19 28 Unrecorded

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 16

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 16, 19 28, to

19

that I last saw him alive on

19

and that death occurred, on the date stated above, at 12:15 AM

The CAUSE OF DEATH* was as follows:

Stillborn Child of 6 clamping
mother. Apparently dead
about 2 days (duration)* 0 yrs. 0 mos. 0 ds.CONTRIBUTORY
(Secondary)(duration) 0 yrs. 0 mos. 0 ds.18. Where was disease contracted
if not at place of death? noDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry L. Wilkerson

M. D.

June 18, 19 28 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Idaho Falls Ida June 16 1928

20. Undertaker

Address

H. F. M. Ham Idaho Falls
Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 2 1928

STATE OF IDAHO

County of Cass

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of Melba

CERTIFICATE OF BIRTH

No. 363111 014 225 St. 2

Registration District No. 7 State File No. S 162767

(If born in hospital or institution give name.)

Prim. Registration District No. 2006 Local Registrar's No. 110

FULL NAME OF CHILD Male Coleman

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>June 11</u> 19 <u>28</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 4 (a) Born alive and now living 2

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME James L Coleman

MOTHER
FULL MAIDEN NAME Eva S. Green

Residence (Usual place of abode) Melba, Id

Residence (Usual place of abode) Melba, Id

If nonresident, give place and State

If nonresident, give place and State

Color or race W. Age at last Birthday 40 (Years)

Color or race W Age at last Birthday 38 (Years)

Birthplace Nebraska (City and State or Country)

Birthplace Texas (City and State or Country)

Occupation Farmer

Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

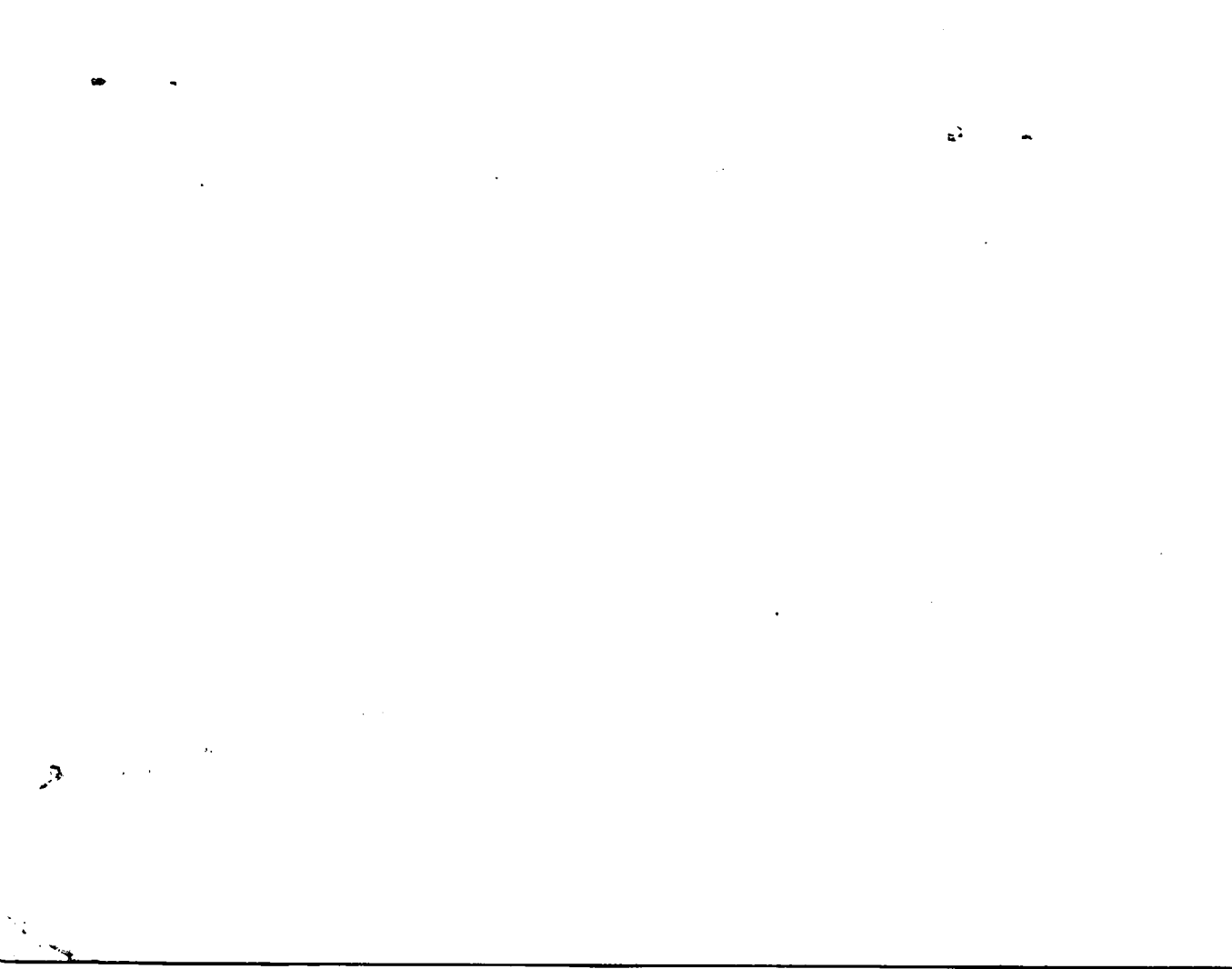
I hereby certify that I attended the birth of this child, who was Stillborn at 8:15 P. M. on the date above stated.

(Signature) Samuel Abney
M.D.
(Physician or midwife)

Address Hamlet, Id

Filed 6-29 1928 MacFarby Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JUL 2 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 62201

PLACE OF DEATH

County of Canyon
City of Melba

Registration District No. 7006
Primary Registration District No. 7006

Local Registrar's No. 70

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Coleman

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 11/1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
— — Full term

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Melba

10. NAME OF FATHER Jim Coleman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Martha

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant Jim Coleman
(Address) Melba

15. Filed 6-27-28 Max Kerby
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 11 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11, 1928, to June 11, 1928, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Premature separation of umbilical cord.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. M. Dwyer M. D.

_____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Meridian Id. 6/12/28

20. Undertaker B. W. Robison Address Meridian

Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

AUG 20 1901

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH JUL 2 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 162908

County of Idaho
City of Grangeville

No. 389-214-25-289 St.

Registration District No. 103

State File No.

(If born in hospital or institution give name.)

Birth Registration District No. 1001 Local Registrar's No. 131

FULL NAME OF CHILD

Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin <u> </u> Triplet <u> </u> or other? <u> </u> (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>6-14-1928</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead Stillborn 1

FULL NAME FATHER Smith Elbert Thresher

FULL MAIDEN NAME MOTHER Ruth Melinda Shing

Residence (Usual place of abode) Grangeville Ida

Residence (Usual place of abode) Grangeville Ida

If nonresident, give place and State

If nonresident, give place and State

Color or race white Age at last Birthday 35
(Years)

Color or race white Age at last Birthday 36
(Years)

Birthplace Mo.
(City and State or Country)

Birthplace Mo
(City and State or Country)

Occupation Furnace

Occupation Sawmills

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

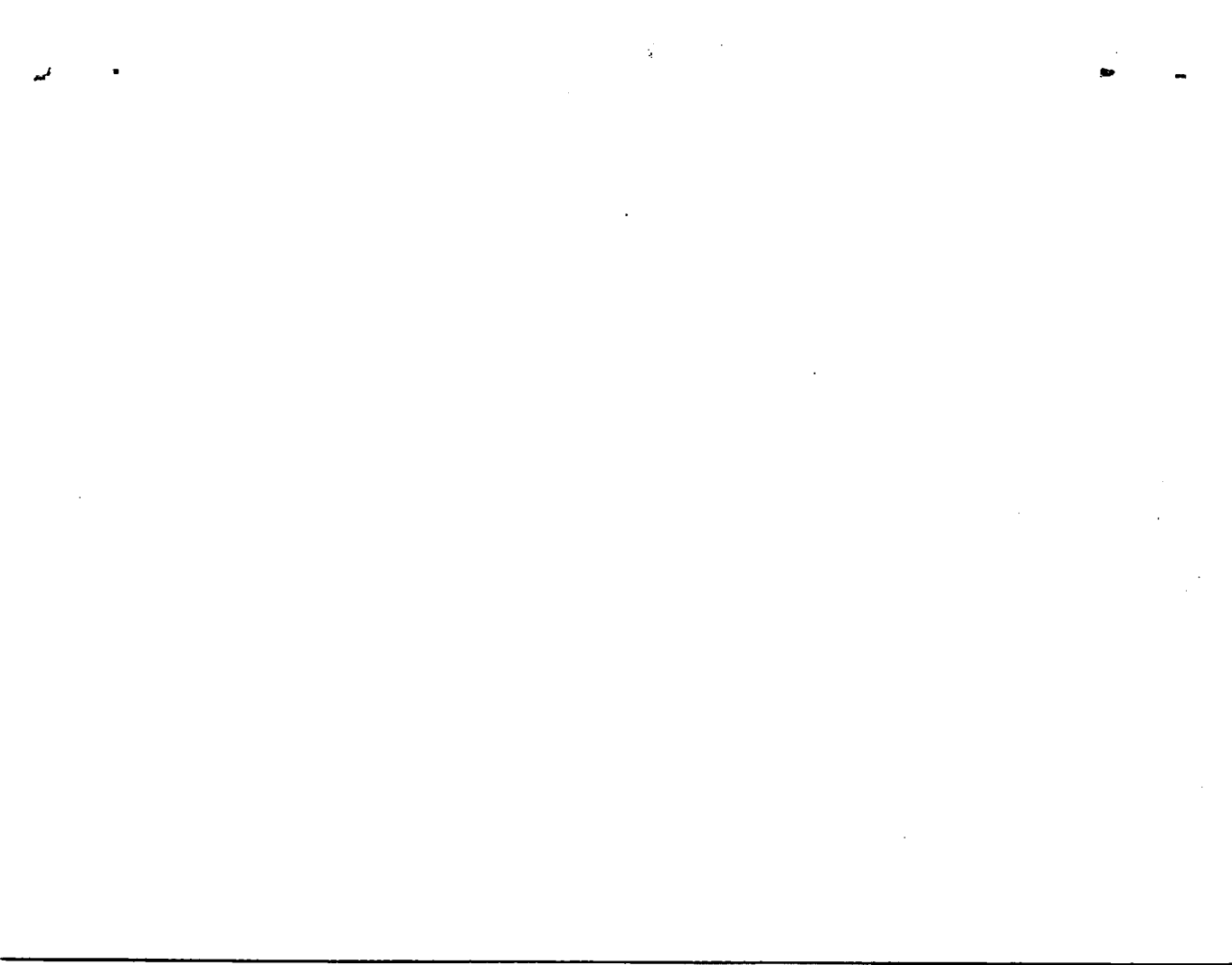
I hereby certify that I attended the birth of this child, who was Stillborn at 10:30 A. M. on the date above stated.

(Signature) B. Chipman
Physician
(Physician or midwife)

Address Grangeville Ida.

Filed 6-30-1928 B. Chipman
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED JUL 2 1928

PLACE OF DEATH

County of *Idaho*City of *Grangeville*STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. *103*Primary Registration District No. *1001*

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. *62264*Local Registrar's No. *67*2. FULL NAME *Stillborn*

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX *Female* 4. COLOR OR RACE 5. Single, Married, Widowed, or Divorced (write the word)5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) *June 14 - 1928*

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) *Grangeville Ida.*
(State or country)10. NAME OF FATHER *Smith E. Thrasher*11. BIRTHPLACE OF FATHER (city or town)
(State or Country)12. MAIDEN NAME OF MOTHER *Ruth A. Shira*13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) *mo.*14. Informant *S E Thrasher*
(Address) *Grangeville Ida.*15. Filed *6-30-1928* *B. Chipman*
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *June 14 - 1928*

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19, to , 19,

that I last saw h. alive on , 19,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature Separation of Placenta

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *B. Chipman* M. D.*6-14-1928* (Address) *Grangeville Ida.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

*Grangeville Ida.**6-14-1928*

20. Undertaker

Address

*E. S. Lunceock**Grangeville Ida.*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

RECEIVED JUL 13 1928

STATE OF IDAHO

County of Jerome

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of Jerome

CERTIFICATE OF BIRTH

No. 247-230-027410Registration District No. 18 State File No. 162931St. Valentine Hospital

(If born in hospital or institution give name.)

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin <u>other</u> Triplet <u>other</u> or other?	and { Number in order of birth 1	Legitimate? <u>yes</u>	Date of birth <u>June 30</u> 19 <u>28</u> (Month) (Day) (Year)
----------------------------	--	--	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? yesNumber of child of this mother, including present birth 1 (a) Born alive and now living 1

Born alive but now dead Stillborn

FATHER
FULL NAME S. SugigamaResidence (Usual place of abode) Jerome

If nonresident, give place and State

Color or race Japanese Age at last Birthday 53 (Years)Birthplace Japan (City and State or Country)Occupation FarmingMOTHER
FULL MAIDEN NAME Shina MakanoResidence (Usual place of abode) Jerome

If nonresident, give place and State

Color or race Japanese Age at last Birthday 30 (Years)Birthplace Japan (City and State or Country)Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7:30 P. M. on the date above stated.(Signature) Chas F Zeller M.D.

(Physician or midwife)

Address Jerome IdahoFiled 6/30 1928 Chas F Zeller Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

100261

CLASSIFIED BY 3343

7-10-64

UNITED STATES DEPARTMENT OF AGRICULTURE

[illegible]

... ..

U.S. and State of Georgia)

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

There is a very interesting photograph of a man in a military uniform, possibly a pilot, standing next to a car. The man is wearing a dark uniform with a light-colored shirt and a tie. The car is a dark-colored sedan. The background is a light-colored wall.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 27 1928

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Jerome*

City of *18 1/2 N*

If death occurs away from usual residence, give facts called for under special information.

Registration District No. *- 18*

Primary Registration District No.

(No. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *63065*

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Unborn Sigiyaama*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Japanese* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *White*

6. DATE OF BIRTH *June 30 1928*

7. AGE *Stillborn* IF LESS than 1 day how many hrs. or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) *Idaho*

10. NAME OF FATHER

Sam Sigiyaama

11. BIRTHPLACE OF FATHER

(State or Country) *Japan*

12. MAIDEN NAME OF MOTHER

Satsu Mackino

13. BIRTHPLACE OF MOTHER

(State or Country) *Japan*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Sam Sigiyaama*

(Address) *Jerome*

15. Filed *6/30 1928* *Chas F Zeller*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 30 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 30 1928 to June 30 1928
that I last saw him alive on *June 30 1928*

and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Still Born Infant
Meningococci

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Chas F. Zeller* M. D.

7/3 1928 (Address) *Jerome, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Cemetery

July 1 1928

20. UNDERTAKER

ADDRESS

D A Hemison

Jerome

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

279 216 029 '29

PLACE OF RECEIVED JUL 5 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Latah

City of Moscow

No. 720 So. Main St.

Registration District No. 61

File No. 162971

Hospital The Grutman

Primary Registration District No. 1011

Registered No. 66

FULL NAME OF CHILD

"Stillborn"

Spray

(Certificate of no value without full name of child.)

Sex of Child Female

Twin
Triplet
or other?

{ and }

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

June 16 1928
(Month) (Day) (Year)

(To be answered only in event of plural births)

What bacteriocidal solution was used in eyes?

Number of child of this mother, including present birth. 2

Number of child of this mother now living, including present birth. 0

FATHER
FULL NAME John Henry Spray

RESIDENCE Moscow Idaho

COLOR White AGE AT LAST BIRTHDAY 29 (Years)

BIRTHPLACE Missouri

OCCUPATION Still Worker

MOTHER
FULL MAIDEN NAME Unie Elizabeth Kirk

RESIDENCE Moscow

COLOR White AGE AT LAST BIRTHDAY 26 (Years)

BIRTHPLACE Missouri

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 12:00 A.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) C. O. Grunstrom M.D.

(Physician or midwife)

Give names added from a supplemental report.

Address

Filed June 22 1928 W. H. Carithers

Registrar.

Registrar.

RECEIVED JUL 5 1928

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of LatahRegistration District No. 61Primary Registration District No. 1011File No. 62288City of McSECW

(No. _____ St.)

Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME STILLBORN)SPRAY

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

June 16 1928
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) McSECW, Idaho

10. NAME OF FATHER

J. H. Spray

11. BIRTHPLACE OF FATHER

(State or Country) Mo.

12. MAIDEN NAME OF MOTHER

Bessie Kirk

13. BIRTHPLACE OF MOTHER

(State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Spray(Address) McSECW, Idaho15. June 16 1928 W. H. Carithers
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 16 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 16 1928 to June 16 1928
that I last saw him Alive on Stillborn 19

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Forced pregnancy of mother 7 1/2 months prior to death birth of infant.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary) 1 1/2 mo. when gestation

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) J. H. Carithers M. D.6/16/1928 (Address) McSECW, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

McSECW

DATE OF BURIAL

6/16/28 19

20. UNDERTAKER

F. R. Short

ADDRESS

McSECW

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

295-216031-231
PLACE OF BIRTH
RECEIVED JUL 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

163007

County of Lewis Registration District No. 60 File No. _____
City of Winchester Hospital _____ Primary Registration District No. 44 Registered No. 26

FULL NAME OF CHILD

Evelyn May King
(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>+</u> and Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>June 16</u> 192 <u>8</u> (Month) (Day) (Year)
----------------------------	---	------------------------	---

What bacteriocidal solution was used in eyes? 8

Number of child of this mother, including present birth 6 Number of child of this mother now living, including present birth 3

FULL NAME Robt. D. King
RESIDENCE Winchester
COLOR White AGE AT LAST BIRTHDAY 33 (Years)
BIRTHPLACE Oregon
OCCUPATION R.R. Trades

FULL MAIDEN NAME MOTHER Virginia E. Stanton
RESIDENCE Winchester
COLOR White AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 12:30 A. M.
on the date above stated. (Born alive or stillborn)

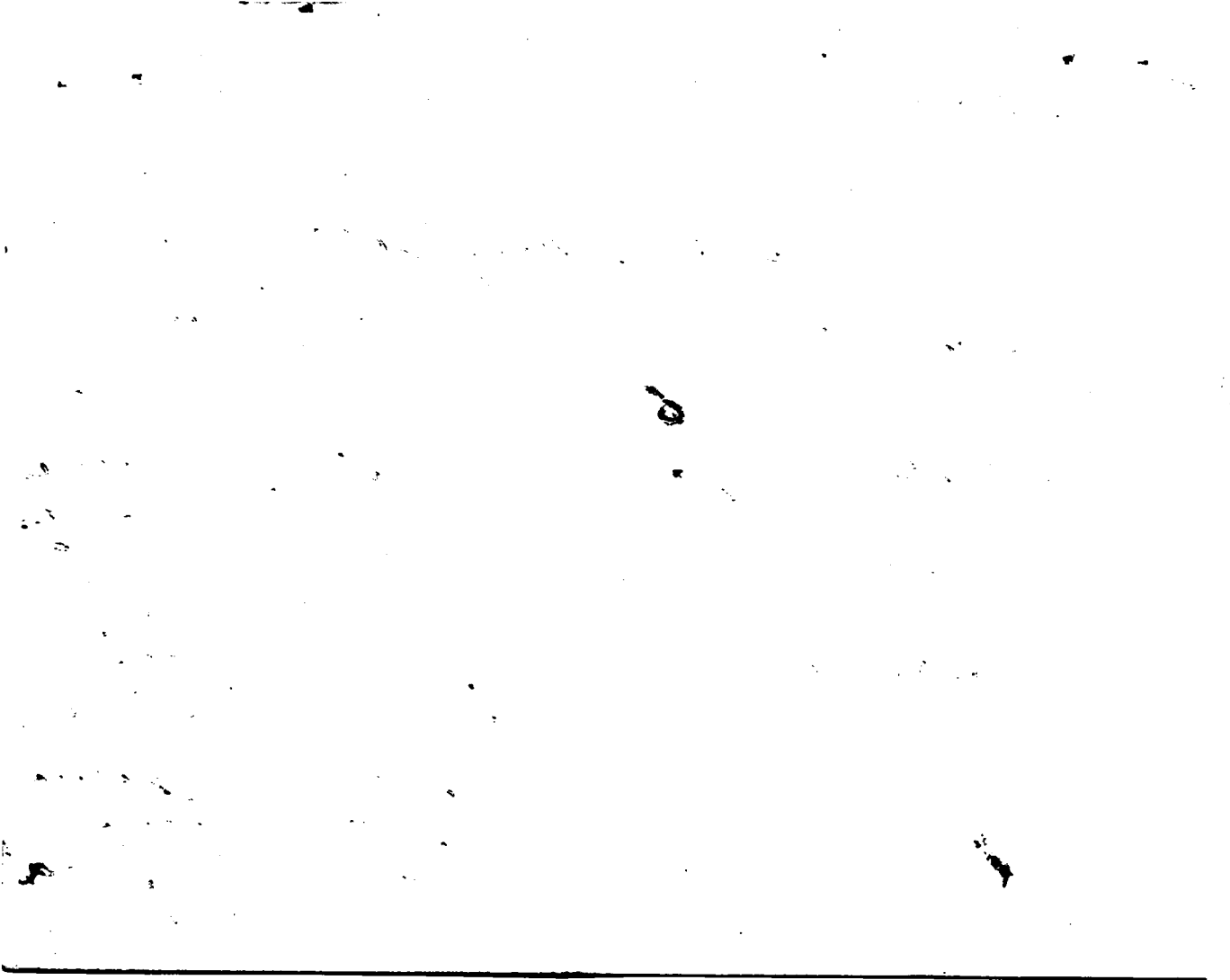
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. C. Langhlin
Physician
(Physician or midwife)

Give names added from a supplemental report.
_____, 19____

Registrar.

Address Winchester, Ida
Filed 6/22/28 1928 R. O. Dineen
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M & 20 11

CERTIFICATE OF DEATH

62302

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Leovis Registration District No. 60
County of Leovis Primary Registration District No. 2129
City of Winchester (No. St.)

File No.
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evelyn May King

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Born dead June 16 1928
(Month) (Day) (Year)

7. AGE yrs. mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Winchester, Idaho

10. NAME OF FATHER Robert D. King

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Virginia E. Stanton

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert D. King
(Address) Winchester, Idaho

15. 6/22 1928 R. D. King
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Born dead June 16 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191

that I last saw h alive on 191 ,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:
Shut dead about 1 wk in utero

(Duration) yrs. mos. ds.
Contributor Long automobile trip
(Secondary)

(Duration) yrs. mos. ds.
(Signed) R. D. King M. D.
6/20 1928 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Woodlawn DATE OF BURIAL June 27 1928

20. UNDERTAKER R. D. King ADDRESS Winchester

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," (Congenital, "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH Payette RECEIVED JUL 9 1928
County of Payette STATE OF IDAHO
City of Payette DEPARTMENT OF PUBLIC WELFARE
No. 1030 Center St. BUREAU OF VITAL STATISTICS
314-208 038 168 CERTIFICATE OF BIRTH
(If born in hospital or institution
give name.) Registration District No. 4 State File No. 43091
Prim. Registration District No. 1008 Local Registrar's No. 44

FULL NAME OF CHILD Opal Bertha Lamb
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>F</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>June 8</u> 19 <u>28</u> (Month) (Day) (Year)
-----------------------	---	--------------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Ag. No. 1%

Number of child of this mother, including present birth 2 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 0

FATHER FULL NAME <u>Charles Grant Lamb</u>	MOTHER FULL MAIDEN NAME <u>Frances Johnson</u>
---	---

Residence (Usual place of abode) Oregon

If nonresident, give place and State Payette, Oregon, Siskiyou Co.

Color or race W. Age at last Birthday 16

Birthplace Colorado (City and State or Country)

Occupation Farmer

Residence (Usual place of abode) Oregon

If nonresident, give place and State Payette, Oregon, Siskiyou Co.

Color or race W. Age at last Birthday 19

Birthplace Payette, Idaho (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive }
on the date above stated. { Stillborn } at 3³⁰ a. M.

(Signature) Meriel R. Fox M.D.

(Physician or midwife)

Address Payette, Idaho

Filed June 30 1928 J. C. Woodward

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

MAY 4 1972

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 5 1928

PLACE OF ISSUE

DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

County of Teton

City of Victor

No. 259-214041-766 St. Registration District No. 77 State File No. 163121

Hospital _____ Primary Registration District No. 3176 Local Registrar's No. 46

FULL NAME OF CHILD _____
(Certificate of no value without full name of child)

Sex of Child <u>Girl</u>	Twin Triplet or other? _____ } and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>6</u> <u>14</u> <u>1928</u> (Month) (Day) (Year)
(To be answered only in event of plural births)			

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Edward John Kersey
RESIDENCE Victor
COLOR White AGE AT LAST BIRTHDAY 31 (Years)
BIRTHPLACE Salt Lake City Utah
OCCUPATION Fireman

MOTHER
FULL MAIDEN NAME Ethel Irene Powell
RESIDENCE Victor
COLOR White AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Wilton Wyoming
OCCUPATION House Keeping

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 9 A M M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Mrs Owen B. Lewis

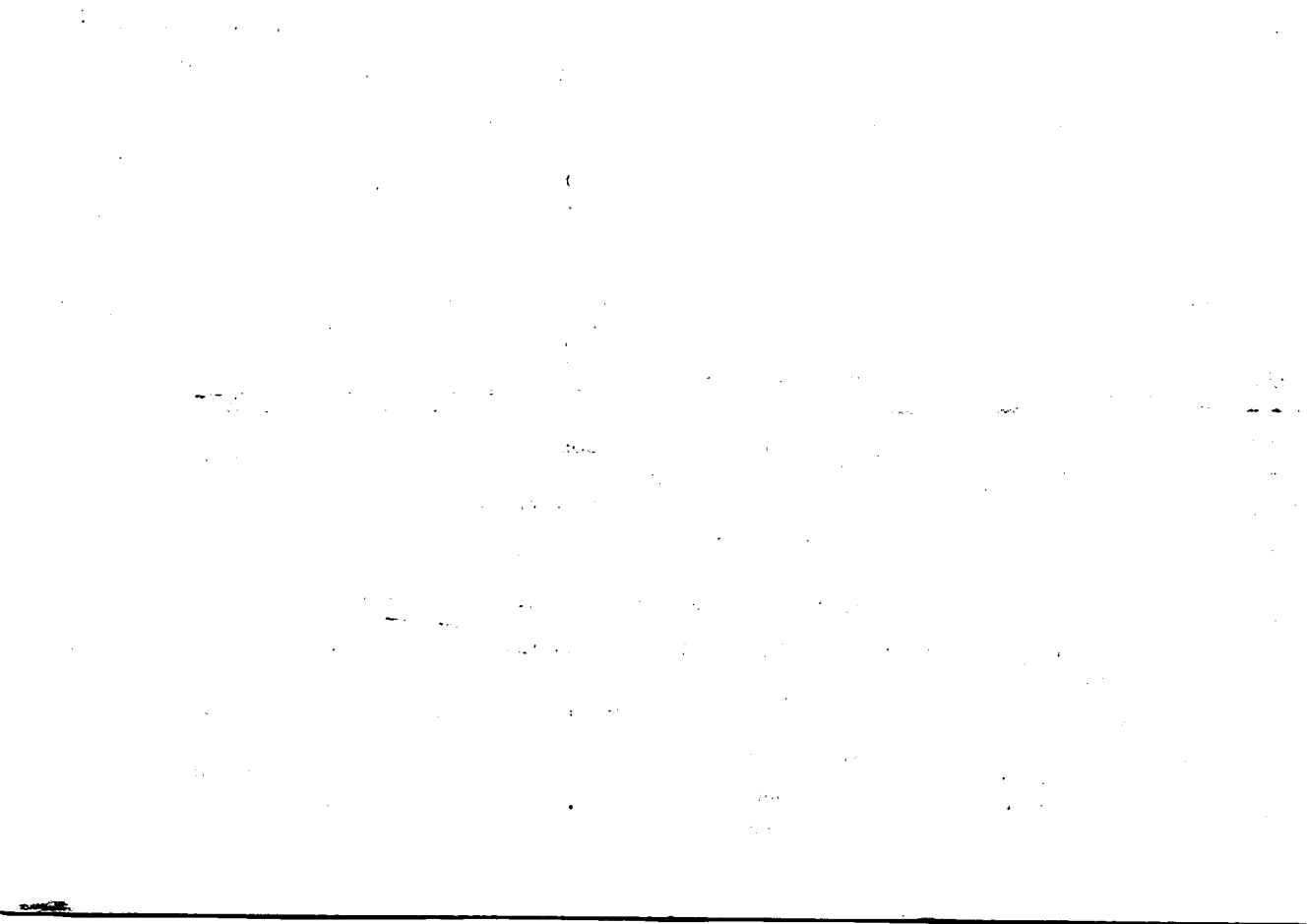
(Physician or midwife)

Address Victor, Ida

Filed 6-30-1928 Martha Marker

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH
County of Teton
City of Victor

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH
Registration District No. 77
Primary Registration District No. 3176
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 62333
Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)
6. DATE OF BIRTH 6-14-1928
(Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day
how many _____ hrs.
Yrs. Mos. ds. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) Victor, Idaho

10. NAME OF FATHER Edward John Kearsley

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Ethel Irene Powell

13. BIRTHPLACE OF MOTHER
(State or Country) Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. O. B. Curtis
(Address) Victor, Idaho

15. Filled 6-30-1928 Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6-14-1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) _____ Yrs. mos. ds.

Contributory
(Secondary)

(Duration) _____ yrs. mos. ds.

(Signed) Martha Marker Registrar M. D.

6-15-1928 (Address) Driggs, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. days. In the State _____ yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Victor, Idaho DATE OF BURIAL 6-15-1928

20. UNDERTAKER _____ ADDRESS _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

RECEIVED JUL 9 1928

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

665-126 042 444
County of Twin FallsCity of Twin FallsNo. 762-2-E St. Registration District No. 37 State File No. 163147Hospital Private sanitarium Primary Registration District No. 1085 Local Registrar's No. -FULL NAME OF CHILD Rale Martin Owen

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>'</u>	and { Number in order of birth <u>'</u>	Legitimate? <u>yes</u>	Date of birth <u>May 26</u> 192 <u>8</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? 10% Neo SilvolNumber of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 4

FATHER

FULL NAME Gas. W. Owens

RESIDENCE Twin Falls, Ida

COLOR White AGE AT LAST BIRTHDAY 69 (Years)

BIRTHPLACE Bucklin, Mo.

OCCUPATION Farmer

MOTHER

FULL MAIDEN NAME Nellie Mamma

RESIDENCE Twin Falls, Ida

COLOR White AGE AT LAST BIRTHDAY 39 (Years)

BIRTHPLACE Eagleville, Mo.

OCCUPATION House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Subborn at 11:44 P.M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

H. E. Lamb
Physician

Address Twin Falls, IdahoFiled 7-10- 1928 H. N. Leete

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

THIS IS A CERTIFICATE OF BIRTH
 AND IS VALID FOR A PERIOD OF ONE YEAR
 FROM THE DATE OF BIRTH
 IN CASE OF DEATH
 IT IS VALID FOR A PERIOD OF ONE YEAR
 FROM THE DATE OF DEATH

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____
 Registration District No. _____
 State File No. _____
 Hospital _____
 Primary Registration District No. _____
 Local Registration No. _____

FULL NAME OF CHILD

Sex of Child _____
 To be entered only in case of plural births
 Number of children in order of birth _____
 Legitimacy _____
 Date of Birth _____
 (Month) (Day) (Year)

What birth-control notation was used in case?

Number of child of this mother, including current birth _____
 Number of child of this mother, now living, including present birth _____

FATHER	MOTHER
FULL NAME	FULL NAME
RESIDENCE	RESIDENCE
COLOR	COLOR
AGE AT LAST BIRTHDAY (Years)	AGE AT LAST BIRTHDAY (Years)
BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____ at _____
 on the date above stated.

When there was no attending physician or midwife, then the father, husband, or mother, should make this return. A child is one that neither precedes nor shows other evidence of its birth.

Give names added from a supplemental report.

102

Registration

Filed _____

102

(Physician's Signature)

MARGIN RESERVED FOR BINDER

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 22052

County of Jim Falls
City of Jim Falls

Registration District No. 37
Primary Registration District No. 1095

Local Registrar's No. 75

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nale Martin Owen

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) <u>May 26 1928</u>		
7. AGE <u>Still Born</u>	Years Months Days	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) Jim Falls Idaho
(State or country)

10. NAME OF FATHER <u>J. W. Owen</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>Missouri</u>
12. MAIDEN NAME OF MOTHER <u>Mellie J. Moonman</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>Missouri</u>

14. Informant J. W. Owen
(Address) Jim Falls, Idaho

15. Filed 6/10/28 H. T. Peet
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 26 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 26th 1928 to May 26 1928
that I last saw him alive on still born
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Still born

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Cretin
(Secondary)
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted _____
if not at place of death? _____
Did an operation precede death? no Date of _____
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) H. E. Lamb, M. D.
May 27, 1928 (Address) Jim Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Jim Falls Idaho Date of Burial 5/28 1928

20. Undertaker Stand Stewart Address Jim Falls Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED JUL 17 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Bannock

City of Pocatello

No. 217-207003851

Hospital St. Anthony

FULL NAME OF CHILD

Registration District No. 28 State File No. 163310

Primary Registration District No. 2161 Local Registrar's No. 2779

Still born

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u> </u>	Date of birth <u>5</u> <u>7</u> <u>1928</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 3

FATHER
FULL NAME Philip Sappington
RESIDENCE 151 Trail Creek Pocatello
COLOR W. AGE AT LAST BIRTHDAY 48 (Years)
BIRTHPLACE St Louis Mo.
OCCUPATION Conductor.

MOTHER
FULL MAIDEN NAME Mabel Heath
RESIDENCE 151 Trail Creek Pocatello
COLOR W. AGE AT LAST BIRTHDAY 42 (Years)
BIRTHPLACE Idaho Falls, Idaho
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 2³⁰ P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) V. A. Head

(Physician or midwife)

Address Pocatello, Idaho

Filed 11 1928

Registrar.

Registrar.

[illegible]

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 16 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. C1653

PLACE OF DEATH
County of BANNOCK
City of POCATELLO

Registration District No. 58

Primary Registration District No. 261

Local Registrar's No. 57

(No. ST ANTHONY HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME BETTIE LEH SAPPINGTON

(a) Residence. No. _____ St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>FEMALE</u>	4. COLOR OR RACE <u>WHITE</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>SINGLE</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) <u>MAY 7, 1928</u>		
7. AGE Years <u>STILLBORN</u>	Months <u>STILLBORN</u>	Days <u>STILLBORN</u>
If LESS than 1 day, hrs. or min.		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) POCATELLO, IDAHO
(State or country)

10. NAME OF FATHER

PHILLIP SAPPINGTON

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

ST LOUIS, MO.

12. MAIDEN NAME OF MOTHER

MABEL HEATH

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

IDAHO FALLS, IDAHO.

14. Informant PHILLIP SAPPINGTON
(Address) POCATELLO,

15. Filed 3/16, 1928

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

MAY
(Month)

7
(Day)

1928
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Still Born, 1928

that I last saw him alive on _____, 1928

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still Born -
And very early death
due to prolonged
labor
(duration) _____ mos. ds.
CONTRIBUTORY
(Secondary)
(duration) _____ yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed)

3/8, 1928 (Address Pocatello, Ida)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

IDAHO, FALLS, IDA.

5/8/ 1928

20. Undertaker

Address

ARTHUR W. HALL

POCATELLO

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Semile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED AUG 6 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock

City of Bancroft

No. 532-224003-259

Registration District No. 84

State File No.

163326

CERTIFICATE OF BIRTH

Hospital

Primary Registration District No. 2161

Local Registrar's No. 544

FULL NAME OF CHILD

Baby Elson (Died)
(Certificate of no value without full name of child)

Sex of Child

Female

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mated

yes

Date of
birth

7-24-1928
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 1

Number of child of this mother now living, including present birth 1

FULL
NAME

FATHER

Mike Elson

RESIDENCE

Bancroft Ida.

COLOR

AGE AT LAST
BIRTHDAY 28
(Years)

BIRTHPLACE

Greene

OCCUPATION

Laborer.

FULL
MAIDEN
NAME

MOTHER

Stella Seibert

RESIDENCE

Bancroft Idaho

COLOR

White

AGE AT LAST
BIRTHDAY 21
(Years)

BIRTHPLACE

Whatcheer Id.

OCCUPATION

Housewife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 2:40 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

(Signature)

E. G. Fitz
M.D.

(Physician or midwife)

Address

Bancroft Idaho

Filed

7-31-1928

Registrar.

Registrar.

000001

Restoration Number No. _____ Date Made No. _____

20710

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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FILED 20 JUL 7 1973

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(To be answered only in event of direct inquiry)

1970 at home and volunteer labiastrated 1971

...to the right of the word "individual" ...

1107
3 MAY

ЗАДАЧА

NAME
MAYBEN
MULL

ЯЗЫКОМ

१०५३०।२३५

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TRAILTAGE
YACHTING

COLON

92A 1947 918

92A-1947-90-9

090700Z

0217A9U230

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

1. I have a recollection that I attended the birth of this child, who was

There was no other person who was in the room at the time of the shooting. The only person who was in the room at the time of the shooting was the person who was shot.

(918188418)

(97-0111 TO 98-0111)

2247113

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b7C

Summary:

[illegible]

FORM V. S. No. 5-25 M. 1-19

RECEIVED AUG 6 1928

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of BancroftCity of BancroftIf death occurs away from
usual residence, give facts
called for under special in-
formation.Registration District No. 87Primary Registration District No. 2161

(No. St.)

File No. 62399Registered No. 128If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

2. FULL NAME

Baby Elson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Never

6. DATE OF BIRTH

July 24 1928
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business or estab-
lishment in which employ-
ed (or employer).

9. BIRTHPLACE

(State or Country)

Bancroft Ida.10. NAME OF
FATHERMike Elson11. BIRTHPLACE
OF FATHER

(State or Country)

Greece12. MAIDEN NAME
OF MOTHERStella Seibert13. BIRTHPLACE
OF MOTHER

(State or Country)

Whatchee Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Birth report copy
Mrs Mike Elson Bancroft

15.

Filed July 31 1928Mrs G. J. Fitz

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

Stillbirth to 19

that I last saw h. alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cause unknown.
Probably dead about
24 hours.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

G. J. Fitz M. D.7/31 1928 (Address) Bancroft Ida.*State the Disease Causing Death; or in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Bancroft

20. UNDERTAKER

Had none.

DATE OF BURIAL

7/24 1928

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF RECEIVED AUG 9 1928 STATE OF IDAHO
County of Bingham DEPARTMENT OF PUBLIC WELFARE
City of Blackfoot BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
No. 99-19 006845 St. Registration District No. 121 State File No. S163365
(If born in hospital or institution give name.) Prim. Registration District No. 1007 Local Registrar's No. 282
FULL NAME OF CHILD Stellborn Privett
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin <input type="checkbox"/> Triplet <input type="checkbox"/> or other? <input type="checkbox"/> and <input type="checkbox"/> Number in order of birth <u>5</u>	Legitimate? <u>Yes</u>	Date of birth <u>July 19</u> 19 <u>29</u> (Month) (Day) (Year)
--------------------------	--	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Yes

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FATHER	MOTHER
FULL NAME <u>Floyd Privett</u>	FULL MAIDEN NAME <u>Emma Hunter</u>
Residence (Usual place of abode) <u>Blackfoot</u>	Residence (Usual place of abode) <u>Blackfoot</u>
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>White</u> Age at last Birthday <u>21</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>19</u> (Years)
Birthplace <u>Oklahoma</u> (City and State or Country)	Birthplace <u>Utah</u> (City and State or Country)
Occupation <u>Laborer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 2:30 9 M.
on the date above stated.

(Signature) W. W. Beck

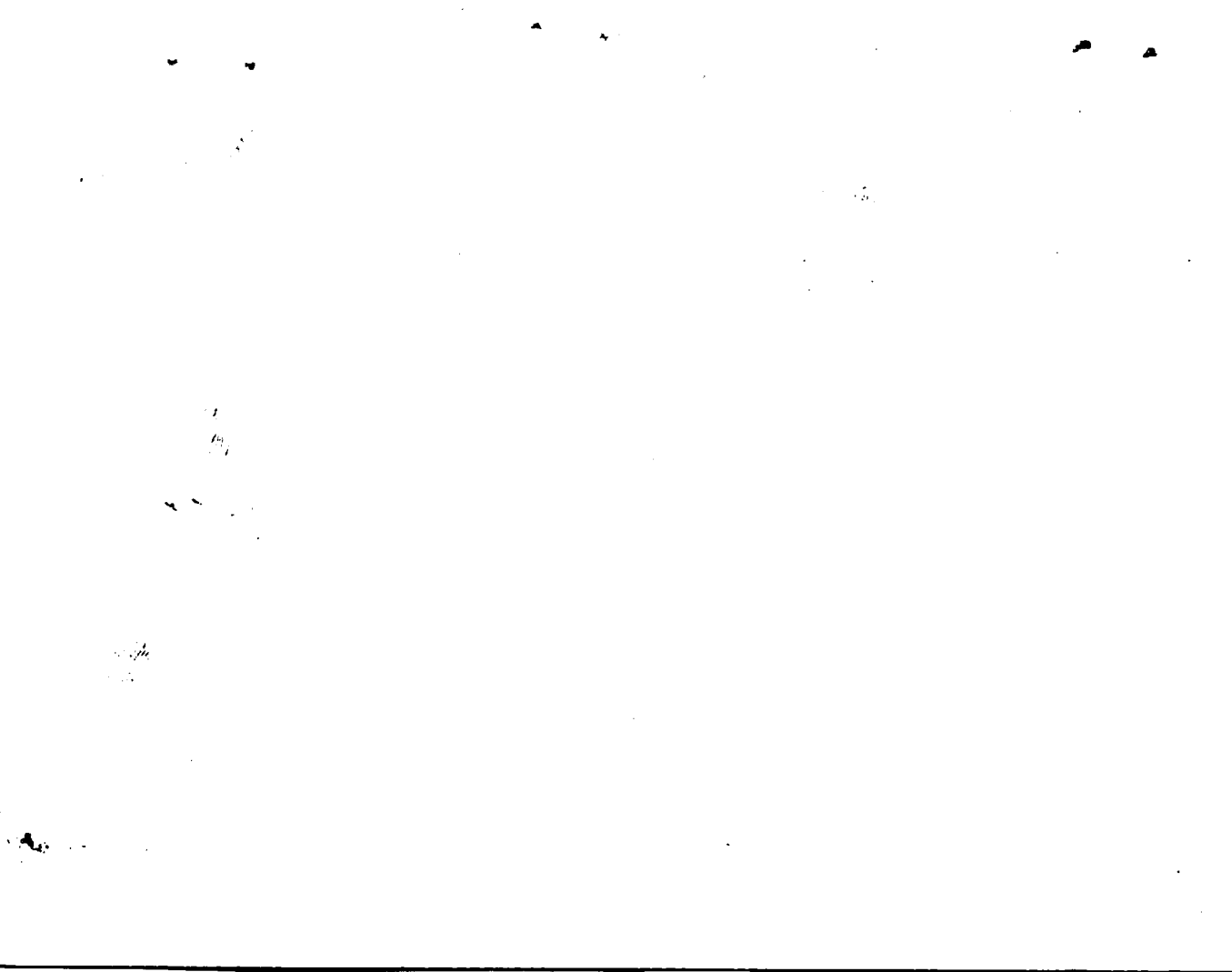
(Physician or midwife)

Address Blackfoot, Idaho

Filed Aug 4 1928 M. W. Water & Talbot

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 9 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

62408

State File No.

Local Registrar's No. 104

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121Primary Registration District No. 1007

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Privett

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) July 19, 1928

7 AGE Stillborn Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Blackfoot, Idaho
(State or country)10 NAME OF FATHER Floyd Privett11 BIRTHPLACE OF FATHER (city or town) Oklahoma
(State or country)12 MAIDEN NAME OF MOTHER Emma Hunter13 BIRTHPLACE OF MOTHER (city or town) Utah
(State or country)

14 Informant Floyd Privett
(Address) Blackfoot, Idaho

15 Filed July 20 1928 F. M. Waller Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Stillborn
July (Month) 19 (Day) 1928 (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____ 19____

that I last saw him Stillborn 19____
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:
6 1/2 months in utero.
I could not determine
high into accident.
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death? _____Did an operation precede death? No Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) W. W. Beck M. D.July 20, 1928 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal W. M. Hook Cadd. Date of Burial July 19 192820. Undertaker Floyd Privett Address Blackfoot Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		RECEIVED AUG 9 1928		STATE OF IDAHO	
County of <u>Pingree</u>		DEPARTMENT OF PUBLIC WELFARE			
City of <u>Beck's Pingree</u>		BUREAU OF VITAL STATISTICS			
CERTIFICATE OF BIRTH				S	
No. <u>136-223006814</u>		Registration District No. <u>181</u>		State File No. <u>163366</u>	
(If born in hospital or institution give name.)		Prim. Registration District No. <u>2194</u>		Local Registrar's No. <u>283</u>	
FULL NAME OF CHILD <u>Stillbirth Atwood</u>					
(If stillborn, substitute the word "Stillbirth" for name of child)					
Sex of Child <u>Female</u>	Twin <input checked="" type="checkbox"/> Triple <input checked="" type="checkbox"/> or other <input checked="" type="checkbox"/>	and {	Number in order of birth <u>One</u>	Legitimate? <u>Yes</u>	Date of birth <u>July 23 1928</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? _____					
Number of child of this mother, including present birth <u>2</u> (a) Born alive and now living <u>0</u>					
Born alive but now dead <u>0</u> Stillborn <u>2</u>					
FATHER			MOTHER		
FULL NAME <u>Earnest Ray Atwood</u>			FULL MAIDEN NAME <u>Mada Hampton</u>		
Residence (Usual place of abode) <u>Pingree, Ida</u>			Residence (Usual place of abode) <u>Pingree</u>		
If nonresident, give place and State _____			If nonresident, give place and State _____		
Color or race <u>White</u> Age at last Birthday <u>34</u> (Years)			Color or race <u>White</u> Age at last Birthday <u>21</u> (Years)		
Birthplace <u>Utah</u> (City and State or Country)			Birthplace <u>Idaho</u> (City and State or Country)		
Occupation <u>Farmers</u>			Occupation <u>Housewife</u>		
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*					
I hereby certify that I attended the birth of this child, who was { Born alive } at <u>11</u> P. M. on the date above stated. { Stillborn }					
(Signature) <u>W. Beck</u>					
(Physician or midwife)					
Address <u>Beck's, Ida</u>					
Filed <u>Aug 4 1928</u> <u>M. O. Clatter</u> Registrar.					

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

2-1-1

10-1-1

1-1-1

1-1-1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

62410

State File No.

Local Registrar's No. 106

RECEIVED AUG 9 1928

PLACE OF DEATH

CERTIFICATE OF DEATH

County of BinghamRegistration District No. 12thCity of PincheePrimary Registration District No. 2194(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Stillborn Adams

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

July 23, 1928

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Pinchee
Idaho

10 NAME OF FATHER

Ernest R. Adams11 BIRTHPLACE OF FATHER (city or town)
(State or country)Utah

12 MAIDEN NAME OF MOTHER

Anna Hampton13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Idaho

14

Informant

(Address)

Wilbert Adams
Pinchee Idaho

15

Filed

July 24, 1928McClure E. Tate
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Stillborn

(Month)

(Day)

19 ____
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19____.

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Hydramnion
6th mo

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY

(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed)

W. W. Beck M. D.
July 24, 1928 (Address) Blackfoot, Ida*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Adams Farm7/24 1928

20. Undertaker

Wilbert Adams

Address

Pinchee

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

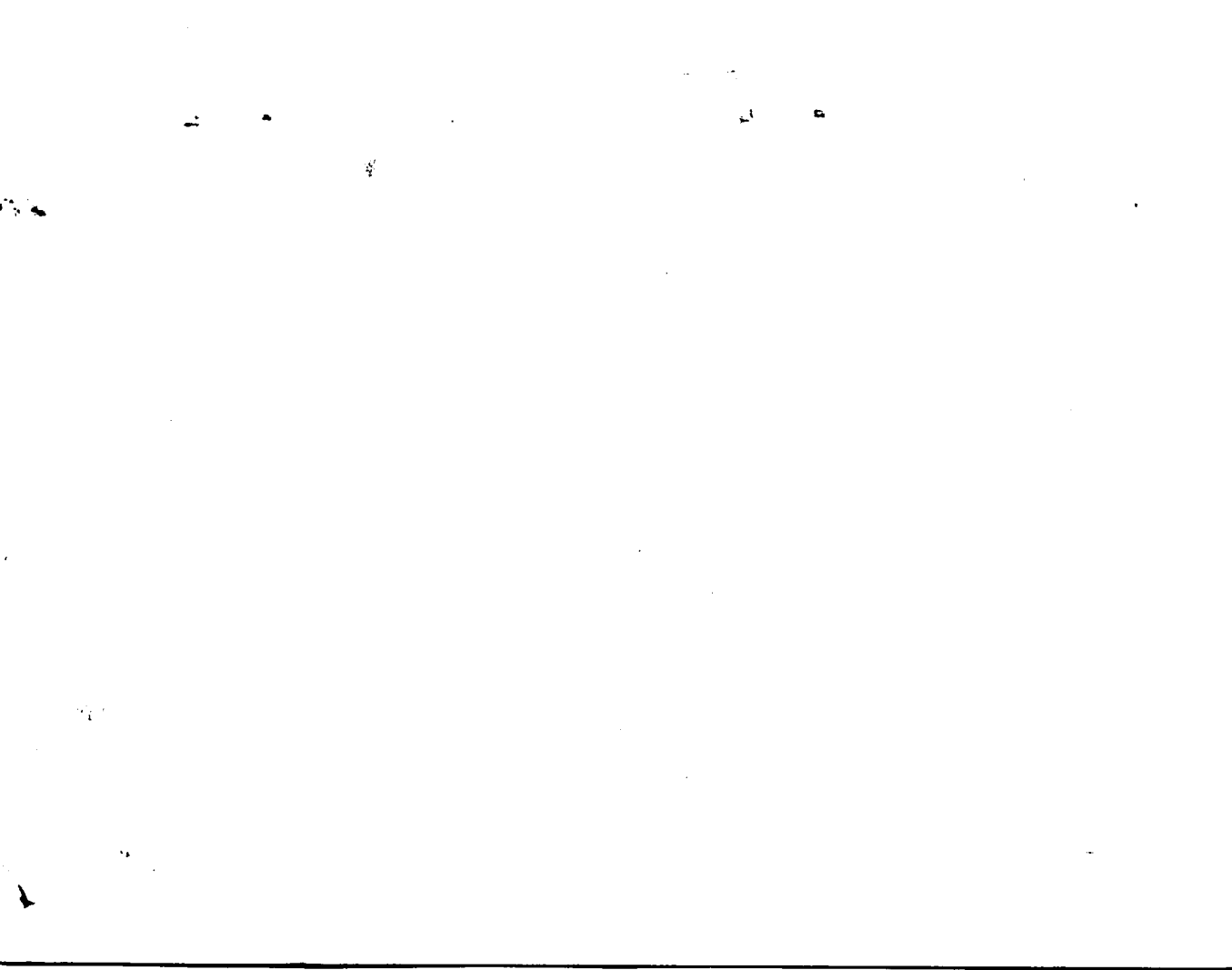
ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
County of <u>Bingham</u>		DEPARTMENT OF PUBLIC WELFARE	
City of <u>Pingree</u>		BUREAU OF VITAL STATISTICS	
No. <u>136,223,006,814</u>		CERTIFICATE OF BIRTH	
(If born in hospital or institution give name.)		Registration District No. <u>121</u> State File No. <u>163367</u>	
FULL NAME OF CHILD <u>Stillbirth Atwood</u>		Prim. Registration District No. <u>2194</u> Local Registrar's No. <u>284</u>	
(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child <u>Female</u>	Twin <u>✓</u> and <u>✓</u> in order of birth <u>✓</u>	Legitimate? <u>Yes</u>	Date of birth <u>July 23</u> 19 <u>28</u>
(To be answered only in event of plural births)			
What prophylactic was used to prevent Ophthalmia Neonatorum? <u> </u>			
Number of child of this mother, including present birth <u>2</u> (a) Born alive and now living <u>0</u>			
Born alive but now dead <u>0</u> Stillborn <u>2</u>			
FATHER		MOTHER	
FULL NAME <u>Earnest Ray Atwood</u>	FULL MAIDEN NAME <u>Mada Hampton</u>		
Residence (Usual place of abode) <u>Pingree</u>	Residence (Usual place of abode) <u>Pingree</u>		
If nonresident, give place and State <u> </u>	If nonresident, give place and State <u> </u>		
Color or race <u>White</u> Age at last Birthday <u>34</u> (Years)	Color or race <u>White</u> Age at last Birthday <u>21</u> (Years)		
Birthplace <u>Utah</u> (City and State or Country)	Birthplace <u>Idaho</u> (City and State or Country)		
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>		
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*			
I hereby certify that I attended the birth of this child, who was <u>Born alive</u> at <u>11:15 P.</u> M. on the date above stated.			
(Signature) <u>W. W. Beck</u>			
(Physician or Midwife)			
Address <u>Blackfoot, Idaho</u>			
Filed <u>Aug 4</u> 19 <u>28</u> <u>Mo. Bates & Talbot</u> Registrar.			

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 9 1928

PLACE OF DEATH

 STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 62411

County of BinghamRegistration District No. 121City of PingreePrimary Registration District No. 2194Local Registrar's No. 107(No. _____)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)2. FULL NAME Stillborn Atwood

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

Stillborn 7/23/28

7 AGE

Years

Months

Days

1 If LESS than
day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Pingree Idaho

10 NAME OF FATHER

Earnest R. Atwood11 BIRTHPLACE OF FATHER (city or town)
(State or country)Utah

12 MAIDEN NAME OF MOTHER

Mada Hampton13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Idaho

14

Informant
(Address)Willbert Atwood
Pingree Idaho

15

Filed

July 24 1928Mollie E. Talbot

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Stillborn
July 23 1928
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Hydramnios
6th mo
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) W. W. Beck M. D.July 24 1928 (Address) Blackfoot, Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Atwood Farm7/24 1928

20. Undertaker

Address

Willbert AtwoodPingree

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months. -

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Bingham
City of Shelley, Idaho

No. 291222006922 St.

(If born in hospital or institution give name.)

FULL NAME OF CHILD

Registration District No. 121

State File No. 163382

Prim Registration District No. 2194 Local Registrar's No. 299

Stillborn Baby Brash

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate?	Date of birth <u>7 22 1928</u> (Month) (Day) (Year)
----------------------------	---	---	------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth _____ (a) Born alive and now living _____

Born alive but now dead _____ Stillborn Stillborn

FATHER FULL NAME <u>R. L. Brash</u>	MOTHER FULL MAIDEN NAME <u>Ruth Ishell</u>
--	---

Residence (Usual place of abode) Salmon Idaho

If nonresident, give place and State _____

Color or race white Age at last Birthday 33 (Years)

Birthplace Nephi Utah (City and State or Country)

Occupation Electrician

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at 6 30 P. M.
on the date above stated.

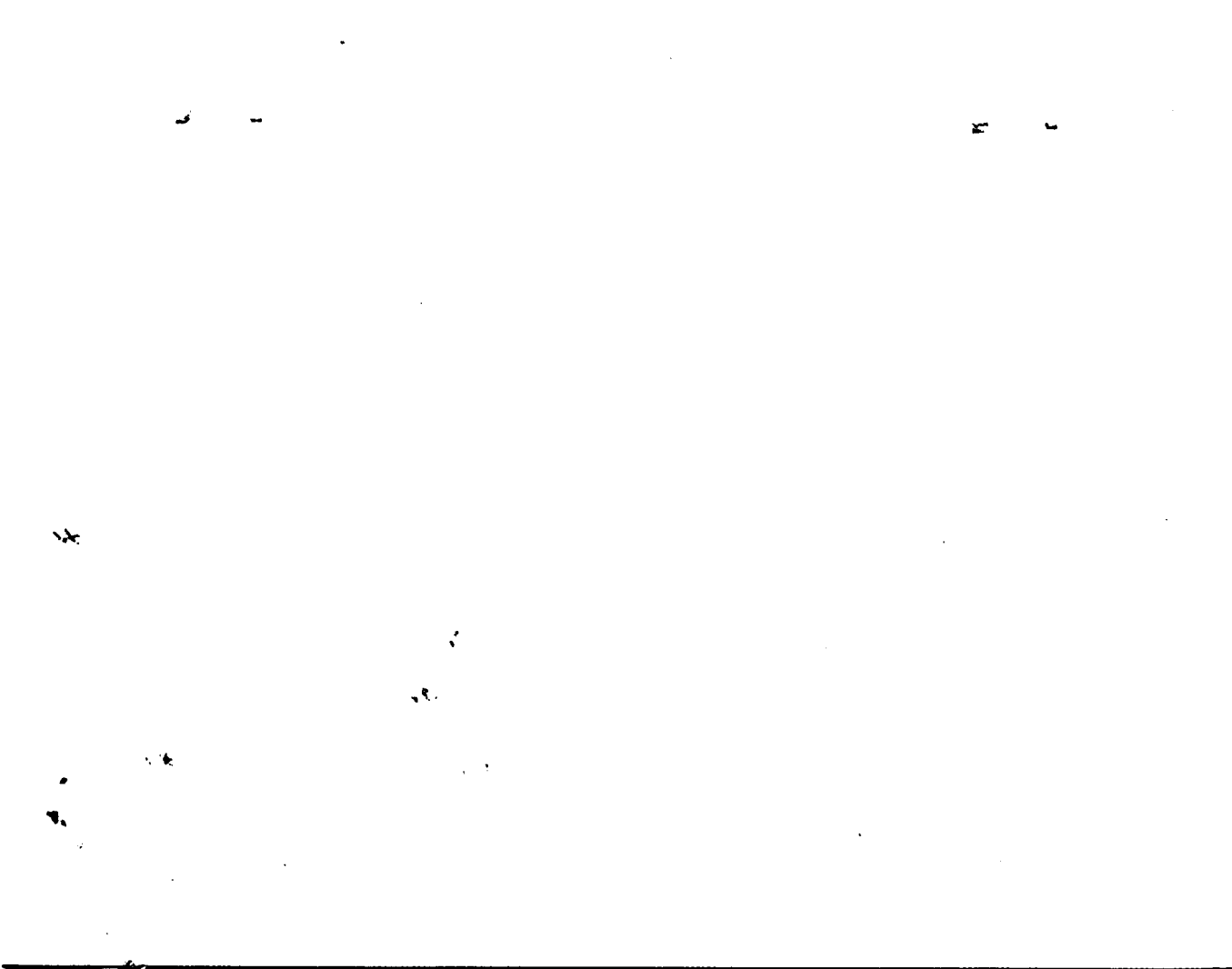
(Signature) Edwin Cuthbert

(Physician or midwife)

Address Shelley, Idaho

Filed Aug 6 1928 M. C. Cates Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. N. 26 OF 1914 RECEIVED AUG 9 1928

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 62413
Registered No. 189

1. PLACE OF DEATH
Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Woodville (State) _____
If death occurs away from usual residence, give facts called for under special information. Shelly R 3
2. FULL NAME Stillborn Baby Brash

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the words)
6. DATE OF BIRTH 7 22 1928
(Month) (Day) (Year)
7. AGE Still born IF LESS than 1 day how many hrs. about 7 months
Yrs. Mos. Wks. or less than 1 day?
8. OCCUPATION giltation
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE Woodville Ida.
(State or Country)
10. NAME OF FATHER R-H Brash
11. BIRTHPLACE OF FATHER Utah
(State or Country)
12. MAIDEN NAME OF MOTHER Ruth Isbell
13. BIRTHPLACE OF MOTHER Richfield Utah
(State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ryan Isbell
(Address) 12-3 Shelly
15. Aug 4 1928
Filed McChales & Co
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH unknown
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from birth
that I last saw him alive on 19
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
unknown
(Duration) Yrs. mos. ds.
Contributory (Secondary) unknown
(Duration) Yrs. mos. ds.
(Signed) Edwin Carter M. D.
7-24-1928 (Address) Shelly
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Yrs. mos. days. In the State Yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence
19. PLACE OF BURIAL OR REMOVAL Woodville Ida. DATE OF BURIAL 7-24-1928
20. UNDERTAKER ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Banner

City of Sandpoint

No. _____ St. _____

319-229 009-355

(If born in hospital or institution give name.)

FULL NAME OF CHILD

Sex of Child

Female

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth } 4

Legitimate?

Yes

Date of birth

7-29
(Month)

1928
(Day)

1928
(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth

(a) Born alive and now living

Born alive but now dead

Stillborn

FULL NAME

FATHER
Carl H Tarr
Selle

FULL MAIDEN NAME

MOTHER
Alma Lee
Selle

Residence (Usual place of abode)

Residence (Usual place of abode)

If nonresident, give place and State

If nonresident, give place and State

Color or race

White

Age at last Birthday

40
(Years)

Color or race

White

Age at last Birthday

35
(Years)

Birthplace

Idaho
(City and State or Country)

Birthplace

Idaho
(City and State or Country)

Occupation

Farmer

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

Born alive
Stillborn

at

5

P. M.

on the date above stated.

(Signature)

W E Allen M D

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address

Sandpoint Idaho

Filed

Aug 3 1928

Viola Allen
Wepully

Registrar.

RECEIVED

AUG 8

1928

STATE OF IDAHO

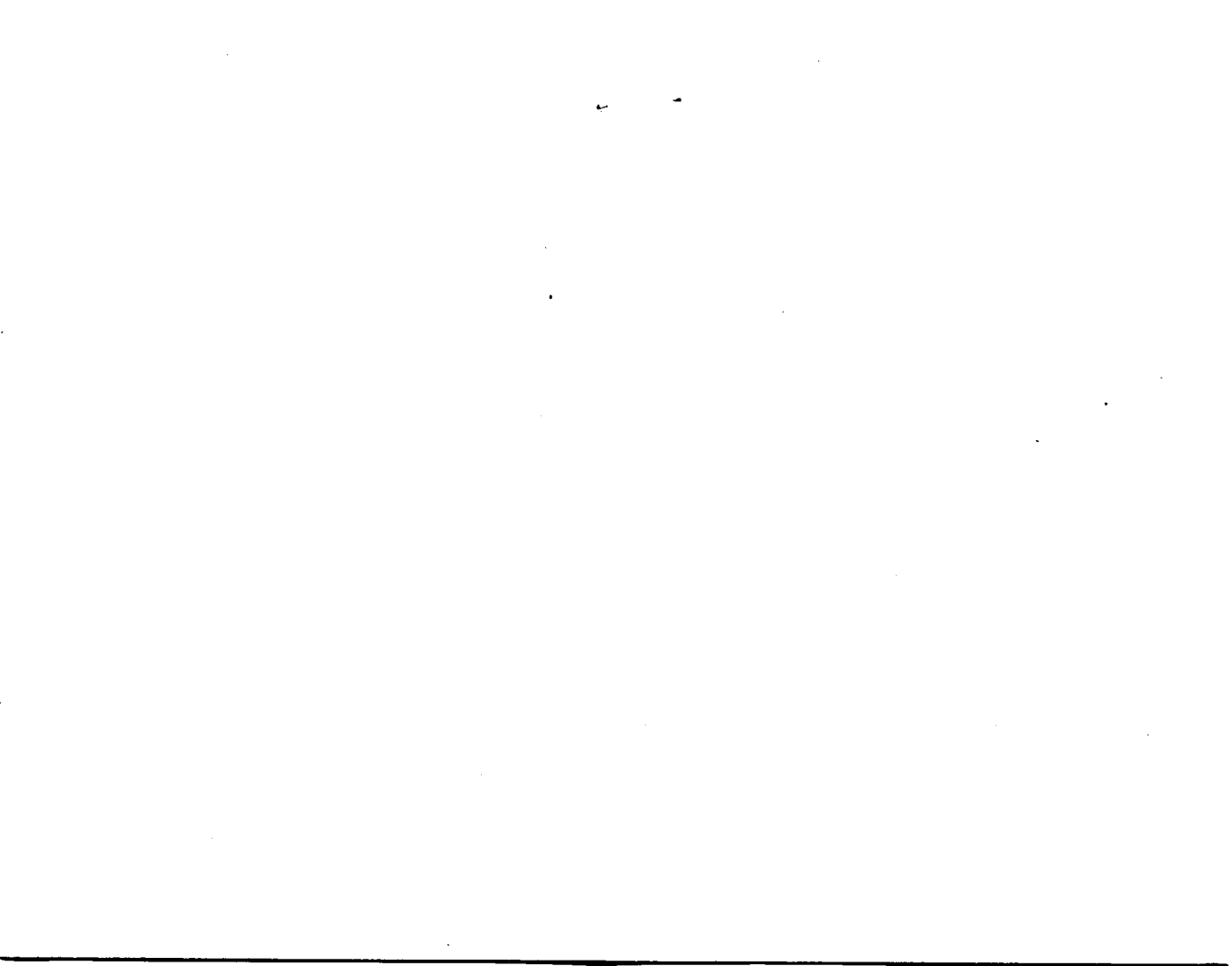
DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

163407

S



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

11230024-345
RECEIVED AUG 8 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Gooding
City of "
No. Gooding St. " Registration District No. 24 File No. 163556
Hospital Gooding Primary Registration District No. " Registered No. 291
FULL NAME OF CHILD Merna Loyce Melton
(Certificate of no value without full name of child.)

Sex of Child <u>girl</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth {	Legiti- mate? <u>yes</u>	Date of birth... <u>Jul 30</u> 192 <u>8</u> (Month) (Day) (Year)
--------------------------	---	---	-----------------------------	--

What bactericidal solution was used in eyes? ✓

Number of child of this mother, including present birth... 1..... Number of child of this mother now living, including present birth... 0.....

FULL NAME <u>Quinn D Melton</u>	FATHER	FULL MAIDEN NAME <u>Loyce Sue</u>	MOTHER
RESIDENCE <u>Gooding Ida</u>		RESIDENCE <u>Gooding Ida</u>	
COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)	COLOR <u>white</u>	AGE AT LAST BIRTHDAY <u>26</u> (Years)
BIRTHPLACE <u>Kansas</u>		BIRTHPLACE <u>Nash</u>	
OCCUPATION <u>Truck driver</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was... J. H. Crumwell 71 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. H. Crumwell

(Physician or midwife)

Give names added from a supplemental report.

Address Gooding Idaho

Filed 7/30 1928

Registrar.

Registrar.

RECEIVED
JAN 11 1967
U.S. AIR FORCE
OFFICE OF THE
JOINT CHIEFS OF STAFF
WASHINGTON, D.C.

RECEIVED
JAN 11 1967
U.S. AIR FORCE
OFFICE OF THE
JOINT CHIEFS OF STAFF
WASHINGTON, D.C.

151

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 8 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

62471

State File No.

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Gardiner

Registration District No. 29

City of Gardiner

Primary Registration District No.

Local Registrar's No. 102

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mervin Loyce Melton

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX girl 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day and year) July 30 28

7 AGE Stellborn Years Months Days 1 If LESS than day, min. hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Gardiner, Ida
(State or country)

10 NAME OF FATHER Quar D Melton

11 BIRTHPLACE OF FATHER (city or town) Kearns
(State or country)

12 MAIDEN NAME OF MOTHER Loyce Lee

13 BIRTHPLACE OF MOTHER (city or town) Nash
(State or country)

14 Informant Quar D Melton
(Address) Gardiner, Ida

15 Filed 7/30, 19 28 JH Cronwell
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Stellborn 7/30-1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ✓, 19 28, to ✓, 19 28

that I last saw him alive on ✓, 19 28

and that death occurred, on the date stated above, at ✓ m.

The CAUSE OF DEATH* was as follows:

Stellborn - feet protrude
from - probable blood
systemic disease
of head (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) JH Cronwell 19 28 (Address) Gardiner, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Gardiner Date of Burial 7-30 1928

20. Undertaker A E Thompson Address Gardiner

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED AUG 9 1928
STATE OF IDAHO
County of Idaho DEPARTMENT OF PUBLIC WELFARE
City of Cottonwood BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S 163560**
No. 445-107-025-152 Registration District No. 105 State File No. 163560
(If born in hospital or institution give name.) Prim. Registration District No. 2183 Local Registrar's No. 27

FULL NAME OF CHILD Still birth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M.</u>	Twin Triplet or other? <u>and</u> { Number in order of birth }	Legitimate? <u>yes</u>	Date of birth <u>May 7</u> 19 <u>28</u> (Month) (Day) (Year)
------------------------	--	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living

Born alive but now dead Stillborn

FATHER FULL NAME <u>Carl J. Munn</u>	MOTHER FULL MAIDEN NAME <u>Dorothy Virginia Jessup</u>
---	---

Residence (Usual place of abode) Minona Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 31 (Years)

Birthplace Wheatland Iowa (City and State or Country)

Occupation Farmer

Color or race White Age at last Birthday 22 (Years)

Birthplace Cottonwood Idaho (City and State or Country)

Occupation House wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who born alive Stillborn } at 7 P. M.
on the date above stated.

(Signature) Hesley Orr M.D.

(Physician or midwife)

Address Cottonwood Idaho

Filed May 30 1928 H. F. Orr per J. B.
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

STATE OF NEW YORK
 COUNTY OF ...
 ...

Registered ...
 ...

... (to name of child)

... (name of ...)
 ... (name of ...)
 ... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

STATE OF NEW YORK
 COUNTY OF ...
 ...

Registered ...
 ...

... (to name of child)

... (name of ...)
 ... (name of ...)
 ... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (name of ...)

... (vertical text on right margin)

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

255-210 028-249
PLACE OF BIRTH

RECEIVED AUG 3 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

163647

County of Kootenai
City of Coeur d'Alene
No. 315 York St.
Hospital C. H. A.

Registration District No. 30 File No. _____
Primary Registration District No. 1051 Registered No. 124

FULL NAME OF CHILD

Alan Benson

(Certificate of no value without full name of child.)

Sex of Child <u>F.</u>	Twin Triplet or other? <u> }</u> and <u> }</u> Number in order of birth <u>2</u>	Legitimate? <u>Yes</u>	Date of birth <u>7</u> <u>10</u> <u>1928</u> (Month) (Day) (Year)
------------------------	--	------------------------	--

What bactericidal solution was used in eyes? none

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 1

FULL NAME Lloyd Benson
RESIDENCE Coeur d'Alene, Ida.
COLOR white AGE AT LAST BIRTHDAY 27 (Years)
BIRTHPLACE Glennwood Minnesota
OCCUPATION Assistant Cashier in bank

FULL MAIDEN NAME Elyabeth Byard
RESIDENCE Coeur d'Alene, Ida.
COLOR white AGE AT LAST BIRTHDAY 29 (Years)
BIRTHPLACE Chicago Ill.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN

I hereby certify that I attended the birth of this child, who was dead at birth 4. H. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

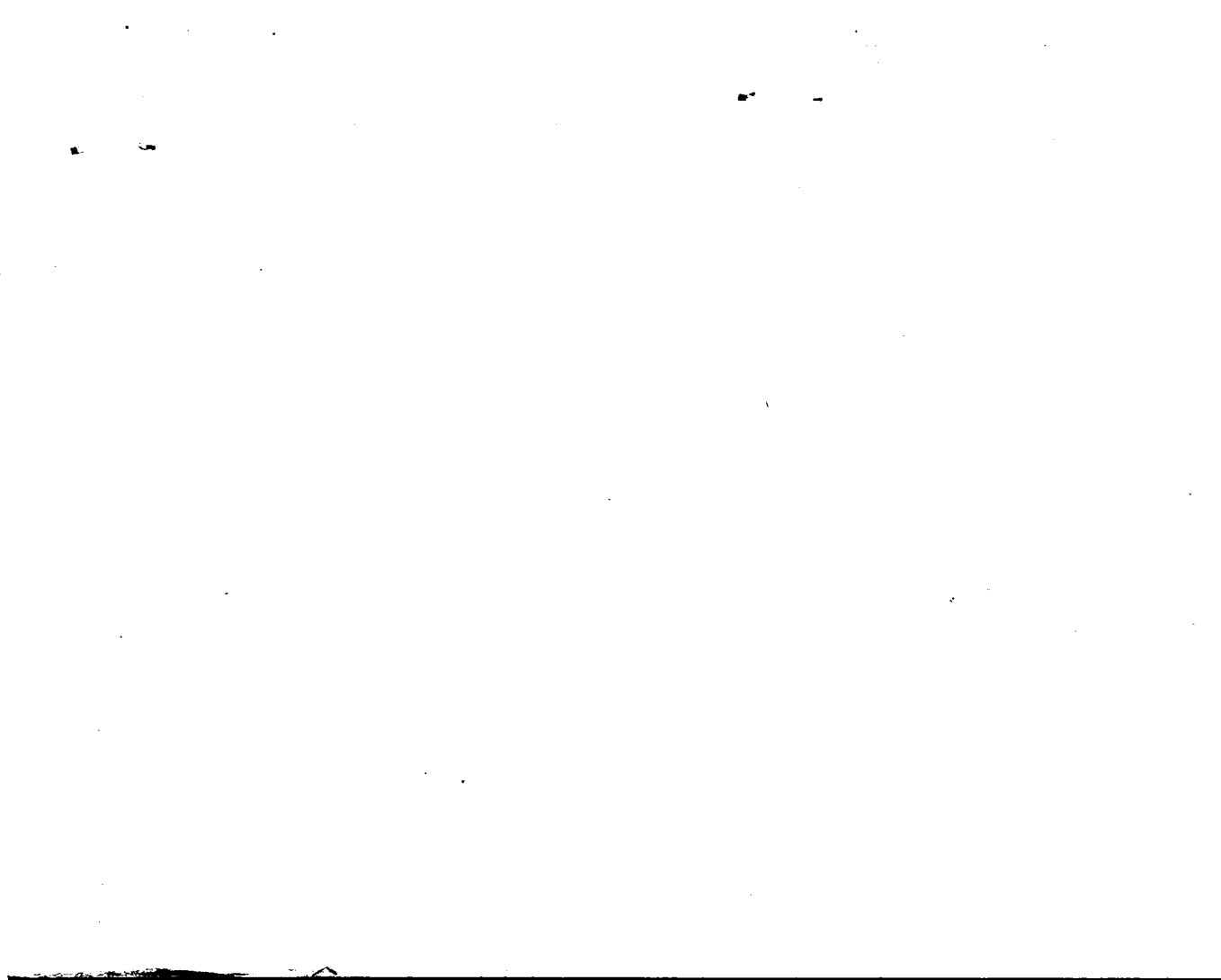
(Signature) W. J. Wood
(Physician or midwife)

Give names added from a supplemental report.

Address _____

_____, 19____
Registrar.

Filed 7/10 1928 D. J. Drennon
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 3 1928

PLACE OF DEATH

County of Keenel
City of Coeur D' Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 20
Primary Registration District No. 1051
(No. Coeur D' Alene Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Benson(a) Residence. No. 309 Park Drive St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) July 10, 1928

7 AGE

Years

Months

Days

1 If LESS than
day, 0 hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Coeur D' Alene,
(State or country) Ida.

10 NAME OF FATHER

Loyd Benson11 BIRTHPLACE OF FATHER (city or town)
(State or country) Minn.

12 MAIDEN NAME OF MOTHER

Elizabeth Buzard13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ill.14 Informant Loyd Benson

(Address)

Coeur D' Alene, Ida.

15 Filled

7/11 1928D. D. Drennan
Registrar

DO NOT WRITE IN THIS SPACE

State File No.

62501Local Registrar's No. 97

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 10 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
July 10, 1928, to July 10, 1928,
that I last saw him alive on _____, 19____,
and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Still born.
Premature detachment of the
placenta.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John M. D.July 10 1928 (Address) Coeur d'Alene
Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Forest Cemetery

20. Undertaker

P B M voney July 10, 28
Address Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

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Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED AUG 3 1928

County of Boole
City of Lane

No. 451710 028-791 St.

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 30 State File No. 163648

Prim. Registration District No. 1051 Local Registrar's No. 125

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

Date of
birth

(Month)

(Day)

(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth

(a) Born alive and now living

Born alive but now dead

Stillborn

FULL
NAME

FATHER

FULL
MAIDEN
NAME

MOTHER

Residence (Usual place of abode)

Residence (Usual place of abode)

If nonresident, give place and State

If nonresident, give place and State

Color or race

Age at last Birthday

(Years)

Color or race

Age at last Birthday

(Years)

Birthplace

(City and State or Country)

Birthplace

(City and State or Country)

Occupation

Occupation

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at N. a. M.
on the date above stated.

(Signature)

(Physician or midwife)

Address

Filed

1/17

1928

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 3 1928

PLACE OF DEATH

County of Nootenai
City of Lane

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 30
Primary Registration District No. 1051

DO NOT WRITE IN THIS SPACE

State File No. 62503Local Registrar's No. 99

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Deal

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 10 - 1928

7. AGE Years Months Days If LESS than 1 day.
0 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lane
(State or country) Idaho

10. NAME OF FATHER W. J. Edgbert Deal

11. BIRTHPLACE OF FATHER (city or town) Traverse
(State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Birth Anna Gray

13. BIRTHPLACE OF MOTHER (city or town) Deer Isle
(State or Country) Maine

14. Informant Mrs. W. E. Deal
(Address) Lane, Ida

15. Filed 7/17, 19 28 D. D. Brennan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 10 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19.....

that I last saw h..... alive on....., 19.....

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

prematurity
Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. H. Field, M. D.

....., 19..... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Lane, Ida. June 10 1928

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

County of Blaine

RECEIVED JUL 16 1928

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

City of Pahsimaroi

CERTIFICATE OF BIRTH

S 163680

No. 96206030-791 St. 41

Registration District No. 41 State File No. 2116

(If born in hospital or institution give name.)

Prim. Registration District No. 2116 Local Registrar's No. 41

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female

Twin
Triplet
or other?

and

Number
in order
of birth

Legitimate? Yes

Date of birth June 6 1928

(Month)

(Day)

(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 5

(a) Born alive and now living 4

Born alive but now dead

Stillborn 1

FULL NAME

FATHER

L. E. Friesman

FULL MAIDEN NAME

MOTHER

Lucile Gray

Residence (Usual place of abode) Pahsimaroi Valley

Residence (Usual place of abode) Pahsimaroi Valley

If nonresident, give place and State ✓

If nonresident, give place and State ✓

Color or race White

Age at last Birthday 29

(Years)

Color or race White

Age at last Birthday 24

(Years)

Birthplace Rocheland Idaho

(City and State or Country)

Birthplace San Antonio Texas

(City and State or Country)

Occupation Laborer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3 P M. on the date above stated.

(Signature) Mrs. Grace Turner

(Physician or midwife)

Address May Idaho

Filed 7/10 1928

Chas. Bellamy

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-11-2000 BY 60322 UCBAW/BJS

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

Registration Serial No. _____
Investigation District No. _____
Date of Birth _____
Full Name of Child _____

At _____
To be answered only
If child is deceased, date of death _____
If child is living, date of birth _____
If child is living, date of death _____
If child is living, date of death _____

At _____
To be answered only
If child is deceased, date of death _____
If child is living, date of birth _____
If child is living, date of death _____
If child is living, date of death _____

At _____
To be answered only
If child is deceased, date of death _____
If child is living, date of birth _____
If child is living, date of death _____
If child is living, date of death _____

At _____
To be answered only
If child is deceased, date of death _____
If child is living, date of birth _____
If child is living, date of death _____
If child is living, date of death _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 1 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 62535

County of Blaine
City of Pahoa
Valley

Registration District No. 41
Primary Registration District No. 2116

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

8. SEX female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word)

16. DATE OF DEATH June 6 - 1928
(Month) (Day) (Year)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:

6. DATE OF BIRTH (month, day and year) June 6 - 28
7. AGE Years Months Days If LESS than 1 day, hrs. or min.

Stillborn
(duration) yrs. mos. ds.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

9. BIRTHPLACE (city or town) Idaho
(State or country)

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of

PARENTS

10. NAME OF FATHER Leroy C Frodsham

Was there an autopsy?

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho

What test confirmed diagnosis?
(Signed) Mrs Grace June M. D.

12. MAIDEN NAME OF MOTHER Russell Gray

_____, 19____ (Address) May Idaho

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. Informant Mrs Grace June
(Address) May Idaho

19. Place of Burial, Cremation, or Removal Date of Burial
May Cemetery 6-7-1928

15. Filled 7/10, 1928 Chris Bellamy
Registrar

20. Undertaker Leroy C Frodsham Address May Idaho

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statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

2253 RECEIVED AUG 13 1928

PLACE OF BIRTH
County of Madison
City of Sugar
No. 386 213 033-249 St.
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. 100 State File No. 163701
Prim. Registration District No. 2178 Local Registrar's No. 137

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth 5 13 1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Mercuro-phenamine

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 1 Stillborn 1

FATHER		MOTHER	
FULL NAME	<u>John E. Thompson</u>	FULL MAIDEN NAME	<u>Luella Smith</u>
Residence (Usual place of abode)	<u>Sugar City</u>	Residence (Usual place of abode)	<u>Sugar City</u>
If nonresident, give place and State		If nonresident, give place and State	
Color or race <u>white</u>	Age at last Birthday <u>22</u> (Years)	Color or race <u>white</u>	Age at last Birthday <u>29</u> (Years)
Birthplace <u>Idaho</u>	(City and State or Country)	Birthplace <u>Idaho</u>	(City and State or Country)
Occupation <u>Farmer</u>		Occupation <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 5-20 A M. on the date above stated.

(Signature) Perin H. Smith

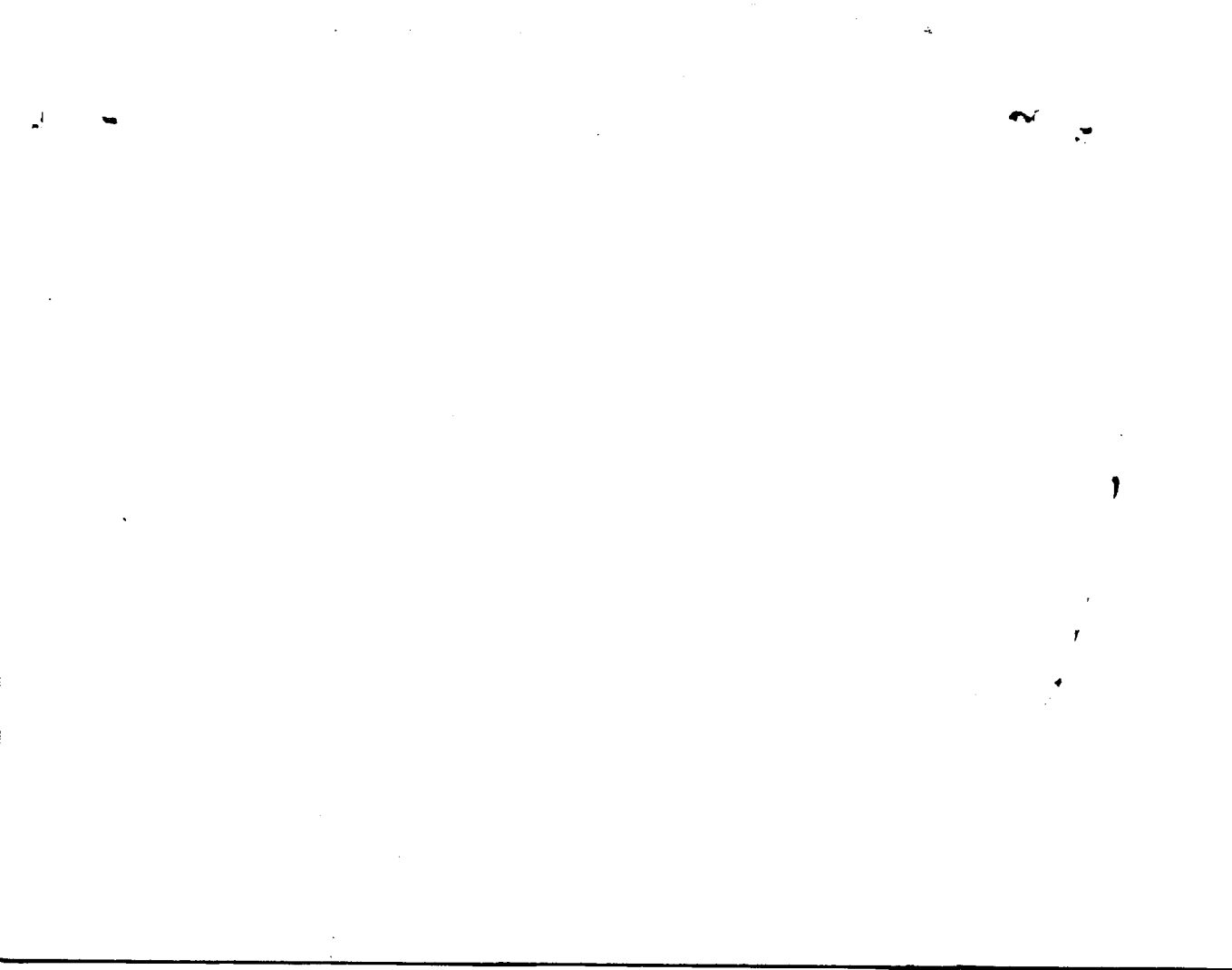
(Physician or midwife)

Address Leeburg, Idaho

Filed 29 19 28 Pyoming

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. C1954

PLACE OF DEATH

County of Madison

City of Sugar City

CERTIFICATE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 26

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Thompson

(a) Residence. No. St.

(Usual place of abode) Etna Wyo. (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.M. 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Babe.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Babe.

6. DATE OF BIRTH (month, day and year) May 13, 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Babe.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sugar City Idaho.
(State or country)

10. NAME OF FATHER John E. Thompson.

11. BIRTHPLACE OF FATHER (city or town) Idaho.
(State or Country)

12. MAIDEN NAME OF MOTHER Luella Smith

13. BIRTHPLACE OF MOTHER (city or town) Salem Idaho.
(State or Country)

14. Informant John E Thompson
(Address) Etna Wyo.

15. Filed 5/14, 1928 J. Young
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 13, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1928, to May 13, 1928

that I last saw alive on, 1928

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Steelborn
Obstruction of cord
due to knot.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis J. Tech M. D.
5-14-, 1928 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Wilford, Idaho. 5/14/28 19

20. Undertaker Address

None. Rexburg

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED AUG 1 1928

PLACE OF BIRTH
County of Stephens
City of Kellogg
No. 795 131 040 666 St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Registration District No. 123 State File No. 163868
(If born in hospital or institution give name.)
Prim. Registration District No. 2201 Local Registrar's No. 88

FULL NAME OF CHILD 6 1/2 yrs. female.
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male Twin Triplet } and { Number in order of birth } Legitimate? yes Date of birth 5/31/1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? yes

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 1

FATHER		MOTHER	
FULL NAME	<u>Wm Lawrence Pinson</u>	FULL MAIDEN NAME	<u>Cora Woods</u>
Residence (Usual place of abode)	<u>Kellogg, Idaho</u>	Residence (Usual place of abode)	<u>Kellogg, Idaho</u>
If nonresident, give place and State		If nonresident, give place and State	
Color or race	<u>White</u> Age at last Birthday <u>27</u> (Years)	Color or race	<u>White</u> Age at last Birthday <u>28</u> (Years)
Birthplace	<u>State of Virginia</u> (City and State or Country)	Birthplace	<u>Hunter, W. Va.</u> (City and State or Country)
Occupation	<u>Farmer</u>	Occupation	<u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 6:45 P. M. on the date above stated.

(Signature) W. B. Fitzgerald
Physician
(Physician or midwife)

Address Kellogg, Idaho

Filed July 30 1928 Ans. Helen M. Brude
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Registration District No. _____ State of N. C. _____

Print Registration Number of the _____ Local Registrar's No. _____

STATE OF CHILDR.

.....

(Date) _____ (Place) _____ (Signature) _____
 (Name) _____ (Address) _____ (City) _____
 (State) _____ (Zip) _____

What in my opinion was used to prevent Optimal Development

(b) - [REDACTED] (c) - [REDACTED]

市: 咖啡, 茶,

WITNESSES

12 FROM

(sheds) in place of sheds

It is recommended that the following be done:

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RECEIVED 1964 JAN 24

020400Z

U.S. DEPARTMENT OF JUSTICE

प्राचीन इतिहास

CERTIFICATE OF ATTENDING PHYSICIAN OF DISTRICT.

on the date above stated.

(940503)

17-00000

4-19-64

*Where there was no attending physician or midwife, when the latter, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Madison

RECEIVED JUL 5 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **82330**

County of *Blaine*

City of *Reelogg*

Registration District No. *123*

Primary Registration District No. *2201*

Local Registrar's No. *26*

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Baby Pinson*

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *N.* 5. Single, Married, Widowed, or Divorced (write the word) *Single*

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) *May 31*

7. AGE Years Months Days If LESS than 1 day, hrs. or min. *less than 1 day*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) *Reelogg*
(State or country)

10. NAME OF FATHER *W. L. Pinson*

11. BIRTHPLACE OF FATHER (city or town) *West Virginia*
(State or Country)

12. MAIDEN NAME OF MOTHER *Carrie May Wood*

13. BIRTHPLACE OF MOTHER (city or town) *Washington*
(State or Country)

14. Informant *W. L. Pinson*
(Address) *Reelogg, Idaho*

15. Filed *June 1, 1928* *Dr. Mrs. Helen J. Orville*
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 31 19*28*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5/31/1928, to *5/31/1928*

that I last saw him *before alive*, 19

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Prematurity
less than 7 mos.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Nephritis in Mother*

(duration) yrs. / mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? *No* Date of _____

Was there an autopsy? *no*

What test confirmed diagnosis? *Urines of Mother*

(Signed) *A. D. Goodenough*, M. D.

6/1/1928, (Address) *Reelogg, Idaho*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Reelogg, Ida *June 1* 1928

20. Undertaker Address

M. C. Thornhill *Reelogg, Ida*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Shoshone AUG 6 1928

City of 12 mi W. of Kelly

No. _____ St. _____

363 122 040 652

(If born in hospital or institution give name.)

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 163871

Registration District No. 123 State File No. _____

Prim. Registration District No. 2201 Local Registrar's No. 91

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>6/22/1928</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? yes

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Thos Eugene Cole</u>	MOTHER FULL MAIDEN NAME <u>Emmie West</u>
---	--

Residence (Usual place of abode) <u>Kelly, Idaho</u>	Residence (Usual place of abode) <u>Kelly, Idaho</u>
--	--

If nonresident, give place and State _____	If nonresident, give place and State _____
--	--

Color or race <u>white</u> Age at last Birthday <u>27</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>26</u> (Years)
--	--

Birthplace <u>Cataldo, Idaho</u> (City and State or Country)	Birthplace <u>Melmont, Idaho</u> (City and State or Country)
---	---

Occupation <u>Lumberman</u>	Occupation <u>Housewife</u>
-----------------------------	-----------------------------

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3:30 P. M. on the date above stated.

(Signature) A. S. Macdonald

(Physician or midwife)

Address Kelly, Idaho

Filed July 30 19 28 Miss Helen M. Bride

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1. The child was born at the residence of the mother, who is a resident of the State of New York.
 2. The child was born at the residence of the mother, who is a resident of the State of New York.
 3. The child was born at the residence of the mother, who is a resident of the State of New York.
 4. The child was born at the residence of the mother, who is a resident of the State of New York.
 5. The child was born at the residence of the mother, who is a resident of the State of New York.
 6. The child was born at the residence of the mother, who is a resident of the State of New York.
 7. The child was born at the residence of the mother, who is a resident of the State of New York.
 8. The child was born at the residence of the mother, who is a resident of the State of New York.
 9. The child was born at the residence of the mother, who is a resident of the State of New York.
 10. The child was born at the residence of the mother, who is a resident of the State of New York.

NAME OF CHILD

Place of Birth

City of

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A newborn child is one that neither breathes nor shows other evidence of life after birth.

Address

(Signature)

I hereby certify that I attended the birth of this child, who was (Signature) at (Signature) on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

(Occupation)

City and State or County

Residence

Color or race

If nonresident, give place and State

Residence (If usual place of abode)

FATHER

MOTHER

Birth date and now dead

Stillborn

Number of child of this mother, including present birth (a) Born alive and now living

Was prophylactic wax used to prevent (b) Syphilis

To be answered only in case of illegitimate birth

Was child ever exposed?

and in case of illegitimate birth

Legitimacy

Birth

Date of

If mother, state the name of child

Local Registrar's No.

Registration District No.

State file No.

CERTIFICATE OF BIRTH

2 16384

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

968-207 042 284
PLACE OF BIRTH RECEIVED
County of Twin Falls
City of Twin Falls
No. R. 2 St.

AUG 13 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Registration District No. 37 State File No. 163915

Prim. Registration District No. 2085 Local Registrar's No. Rayle

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>No</u>	and { Number in order of birth <u>1</u> }	Legitimate? <u>yes</u>	Date of birth <u>7</u> <u>7</u> <u>1928</u>
				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum none

Number of child of this mother, including present birth 11 (a) Born alive and now living 9

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME Robert Rayle

MOTHER
FULL MAIDEN NAME Nora Lee Shull

Residence (Usual place of abode) J. F. R 2

Residence (Usual place of abode) J. F.

If nonresident, give place and State

If nonresident, give place and State

Color or race W Age at last Birthday 53

Color or race W Age at last Birthday 49

Birthplace Nebraska, Ind
(City and State or Country)

Birthplace W. Carolina
(City and State or Country)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 1:30 P. M.
on the date above stated.

(Signature) C. D. Weaver

(Physician or midwife)

Address Twin Falls, Idaho

Filed 8-10-1928 H. W. Lutz

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1. Name of child
 2. Sex
 3. Date of birth
 4. Place of birth
 5. Name of mother
 6. Name of father
 7. Name of attending physician
 8. Name of registrar
 9. Name of hospital
 10. Name of city
 11. Name of state
 12. Name of country
 13. Name of hospital
 14. Name of city
 15. Name of state
 16. Name of country

CERTIFICATE OF BIRTH

STATE OF ILLINOIS
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS

Registration District No. _____ State File No. _____
 Local Registration District No. _____

CHILD WANTED CHILD

To be answered only in case of child birth
 Date of birth _____
 Time of birth _____
 Place of birth _____
 Name of mother _____
 Name of father _____
 Name of attending physician _____
 Name of registrar _____
 Name of hospital _____
 Name of city _____
 Name of state _____
 Name of country _____

If child prophylactic was used to prevent tuberculosis _____
 Name of child _____
 Name of mother _____
 Name of father _____
 Name of attending physician _____
 Name of registrar _____
 Name of hospital _____
 Name of city _____
 Name of state _____
 Name of country _____

Name of child _____
 Name of mother _____
 Name of father _____
 Name of attending physician _____
 Name of registrar _____
 Name of hospital _____
 Name of city _____
 Name of state _____
 Name of country _____

Name of child _____
 Name of mother _____
 Name of father _____
 Name of attending physician _____
 Name of registrar _____
 Name of hospital _____
 Name of city _____
 Name of state _____
 Name of country _____

Name of child _____
 Name of mother _____
 Name of father _____
 Name of attending physician _____
 Name of registrar _____
 Name of hospital _____
 Name of city _____
 Name of state _____
 Name of country _____

Name of child _____
 Name of mother _____
 Name of father _____
 Name of attending physician _____
 Name of registrar _____
 Name of hospital _____
 Name of city _____
 Name of state _____
 Name of country _____

Name of child _____
 Name of mother _____
 Name of father _____
 Name of attending physician _____
 Name of registrar _____
 Name of hospital _____
 Name of city _____
 Name of state _____
 Name of country _____

When there was no attending physician
 or midwife, then the father, mother, or
 other person making this report. A stillborn
 child is one that neither breathed nor
 shows other evidence of life after birth.

RECEIVED JUL 9 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 62343

PLACE OF DEATH

County of Twin Falls,

City of Twin Falls, Ida.

Registration District No. 37

Primary Registration District No. 2085

Local Registrar's No. 89

(No. Twin Falls, Ida, R.F.D. #2)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Rayl

(a) Residence. No. Twin Falls, Ida. #2 St.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. Single, Married, Widowed,
or Divorced (write the word)
Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

July 7th. 1928

7. AGE

Years

Months

Days

If LESS than 1 day,
hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

Twin Falls, Ida.

10. NAME OF FATHER

Robert Rayl

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

Nora Shull

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

North. C

14.

Informant

Robert Rayl,

(Address)

Twin Falls, Ida. R.F.D. #2

15.

Filed

7-10-1928

H. T. Lutz

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 7th.

28

(Month)

(Day)

19
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

1928

that I last saw her stillborn

19

and that death occurred, on the date stated above, at

m.

The CAUSE OF DEATH* was as follows:

Probably dislocated
place of acc.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

D. S. Weaver, M. D.
7/7, 1928 (Address) Twin Falls.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Twin Falls, Ida.

July 7th

19 28

20. Undertaker

J. Grossman,

Address

Twin Falls, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

386124 003-212
PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 164016

RECEIVED AUG 18 1928

County of Blaine

City of Pocatello

No. 317503rd St.

Registration District No. 28

File No. S 164016

Hospital St. Luke's

Primary Registration District No. 3166

Registered No. 2815

FULL NAME OF CHILD Arthur Johnson Thompson

(Certificate has no value without the name of child.)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>and</u>	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>7-24-28</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What bactericidal solution was used in eyes? Still Born

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 8

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Tracy Edgar Thompson</u>	<u>31750 3rd</u>	<u>Bertha Baker</u>	<u>31750 3rd</u>
COLOR <u>Caucasian</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)	COLOR <u>Caucasian</u>	AGE AT LAST BIRTHDAY <u>43</u> (Years)
BIRTHPLACE <u>Idaho</u>		BIRTHPLACE <u>Missouri</u>	
OCCUPATION <u>Laborer</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1:30 a. M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Dr. Lynn

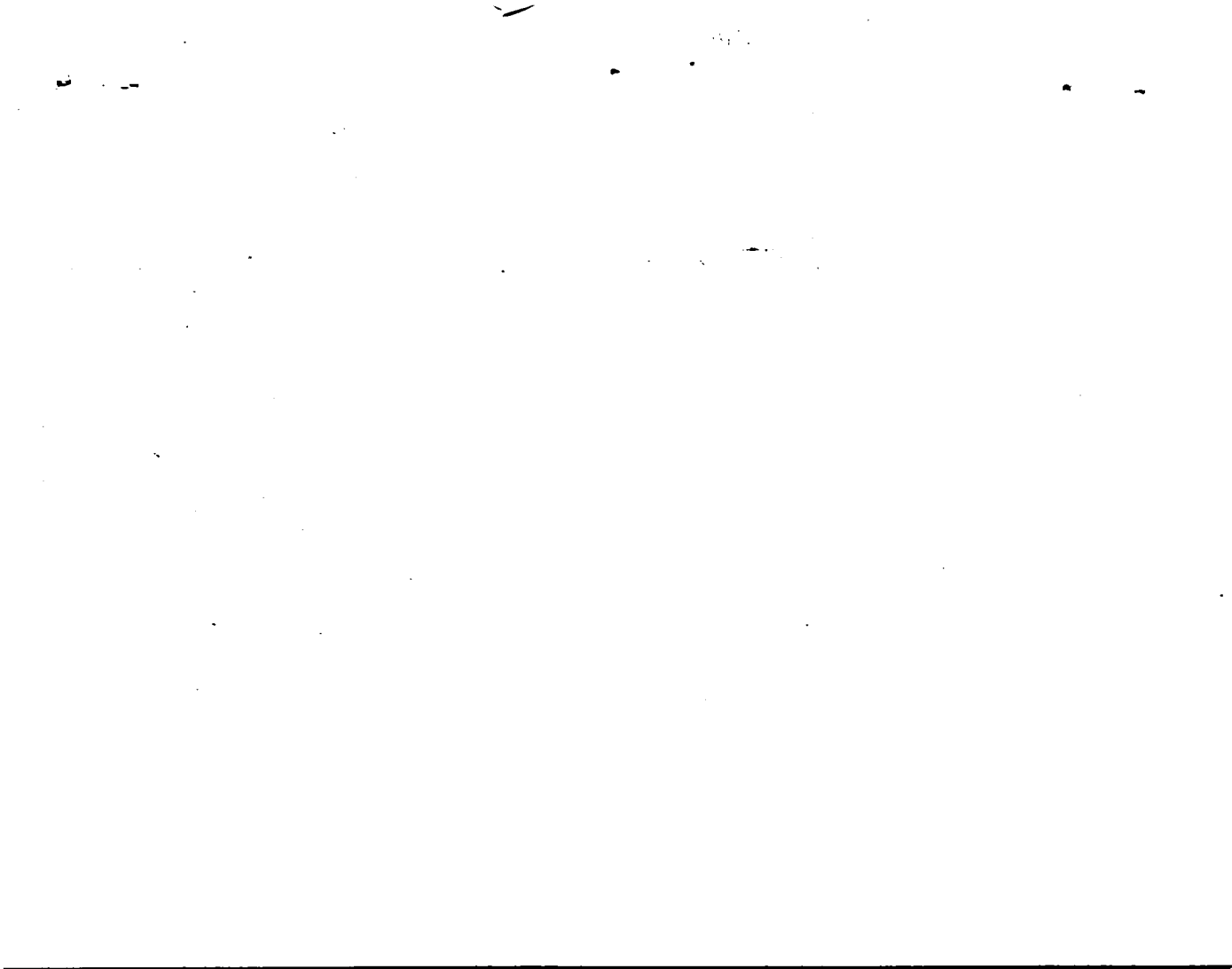
(Physician or midwife)

Give names added from a supplemental report.

Address Pocatello, Idaho

Filed 8/1, 1928 Thompson Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 18 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 62683

PLACE OF DEATH

County of Benewah
City of Pocatello

Registration District No.
Primary Registration District No.

Local Registrar's No. 5339

Arthur Johnson (No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arthur Johnson

(a) Residence. No. 317 N. 3rd Ave. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Colored 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 24-28

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

10. NAME OF FATHER Harry Thompson

11. BIRTHPLACE OF FATHER (city or town) Illeris
(State or Country) Missouri

12. MAIDEN NAME OF MOTHER Bertie Baker

13. BIRTHPLACE OF MOTHER (city or town) Missouri
(State or Country)

14. Informant Anna Thompson
(Address) Pocatello Ida

15. Filed July 24, 1928 J. Young
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 24 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24, 1928, to July 24, 1928
that I last saw him alive on still born

and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) mos. ds.
CONTRIBUTORY Still Born
(Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Young, M. D.

7/24/28 1928 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pocatello Ida Date of Burial July 24 1928

20. Undertaker H. L. McHan Address Pocatello

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever. (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

319-22003-493
PLACE OF BIRTH
County of Bannock
City of Locatello
No. Large Apts St.
Locatello General
(If born in hospital or institution give name.)

RECEIVED SEP 15 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
164088

Registration District No. 38 State File No. 164088

Prim. Registration District No. 2111 Local Registrar's No. 8838

FULL NAME OF CHILD

if stillborn, substitute the word "Stillbirth" for name of child

Sex of Child <u>Female</u>	Twin Triplet or other? <u>—</u> (To be answered only in event of plural births)	and { Number in order of birth <u>—</u>	Legitimate? <u>Y</u>	Date of birth <u>8</u> <u>20</u> <u>1928</u> (Month) (Day) (Year)
----------------------------	--	---	----------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? 1% AgNO₃

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME Lyle H. Cain

Residence (Usual place of abode) _____

If nonresident, give place and State _____

Color or race white Age at last Birthday 37 (Years)

Birthplace Independence Kansas
(City and State or Country)

Occupation Electrician

MOTHER
FULL MAIDEN NAME Elsie M. Wilson

Residence (Usual place of abode) _____

If nonresident, give place and State _____

Color or race white Age at last Birthday 27 (Years)

Birthplace Dronton Ohio
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {
Born alive } at 11:25 P. M.
Stillborn }
on the date above stated.

(Signature) William F. Howard M.D.
(Physician or midwife)

Address Pocatello Idaho

Filed 9 1928 Ilford
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1900

2

RECEIVED SEP 15 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 62699

PLACE OF DEATH

County of BannockCity of PocatelloRegistration District No. 28Primary Registration District No. 2161(No. General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 53552. FULL NAME Baby Cain

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F4. COLOR OR RACE White5. Single, Married, Widowed, or Divorced (write the word) single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6. DATE OF BIRTH (month, day and year) Aug. 20 / 287. AGE Years Months Days If LESS than 1 day, hrs. or min.
— — — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Pocatello
(State or country) Ida.10. NAME OF FATHER L. H. Cain11. BIRTHPLACE OF FATHER (city or town) Independence
(State or Country) Kansas12. MAIDEN NAME OF MOTHER Elsie May13. BIRTHPLACE OF MOTHER (city or town) Ohio
(State or Country)14. Informant L. H. Cain
(Address) 111 Hazgrofts Pocatello15. Filed Aug 21, 1928 J. H. McFar
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 20 1928
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1928 to Aug 20 1928that I last saw him Still born

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows: Asphyxiation (dueto delay birth of body
(duration) yrs. mos. ds. Anaesthetic with etherCONTRIBUTORY (Secondary) _____
(duration) yrs. mos. ds.18. Where was disease contracted if not at place of death? noDid an operation precede death? no Date of _____Was there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) J. H. McFar M. D.of 21, 1928 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pocatello Ida. Date of Burial Aug 21 192820. Undertaker H. L. McFar Address Poca - Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED SEP 10 1928

PLACE OF BIRTH
County of Bingham
City of Blackfoot
No. 136109 006-268 St. _____
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 131 State File No. 16412916
Prim. Registration District No. 2194 Local Registrar's No. 16

FULL NAME OF CHILD Stillborn Atwood
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male Twin ☒ Triplet ☐ or other? ☐ and ☐ Number in order of birth 1
(To be answered only in event of plural births)

Legitimate? Yes Date of birth Aug 9 1928
(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 8 (a) Born alive and now living 7
Born alive but now dead 1 Stillborn one

FATHER		MOTHER	
FULL NAME	<u>Dwan James Atwood</u>	FULL MAIDEN NAME	<u>Lenora Boyd</u>
Residence (Usual place of abode)	<u>Blackfoot</u>	Residence (Usual place of abode)	<u>Blackfoot</u>
If nonresident, give place and State	_____	If nonresident, give place and State	_____
Color or race	<u>White</u>	Color or race	<u>White</u>
Age at last Birthday	<u>31</u>	Age at last Birthday	<u>32</u>
(Years)		(Years)	
Birthplace	<u>Utah</u>	Birthplace	<u>Kentucky</u>
(City and State or Country)		(City and State or Country)	
Occupation	<u>Farmer</u>	Occupation	<u>Housewife</u>

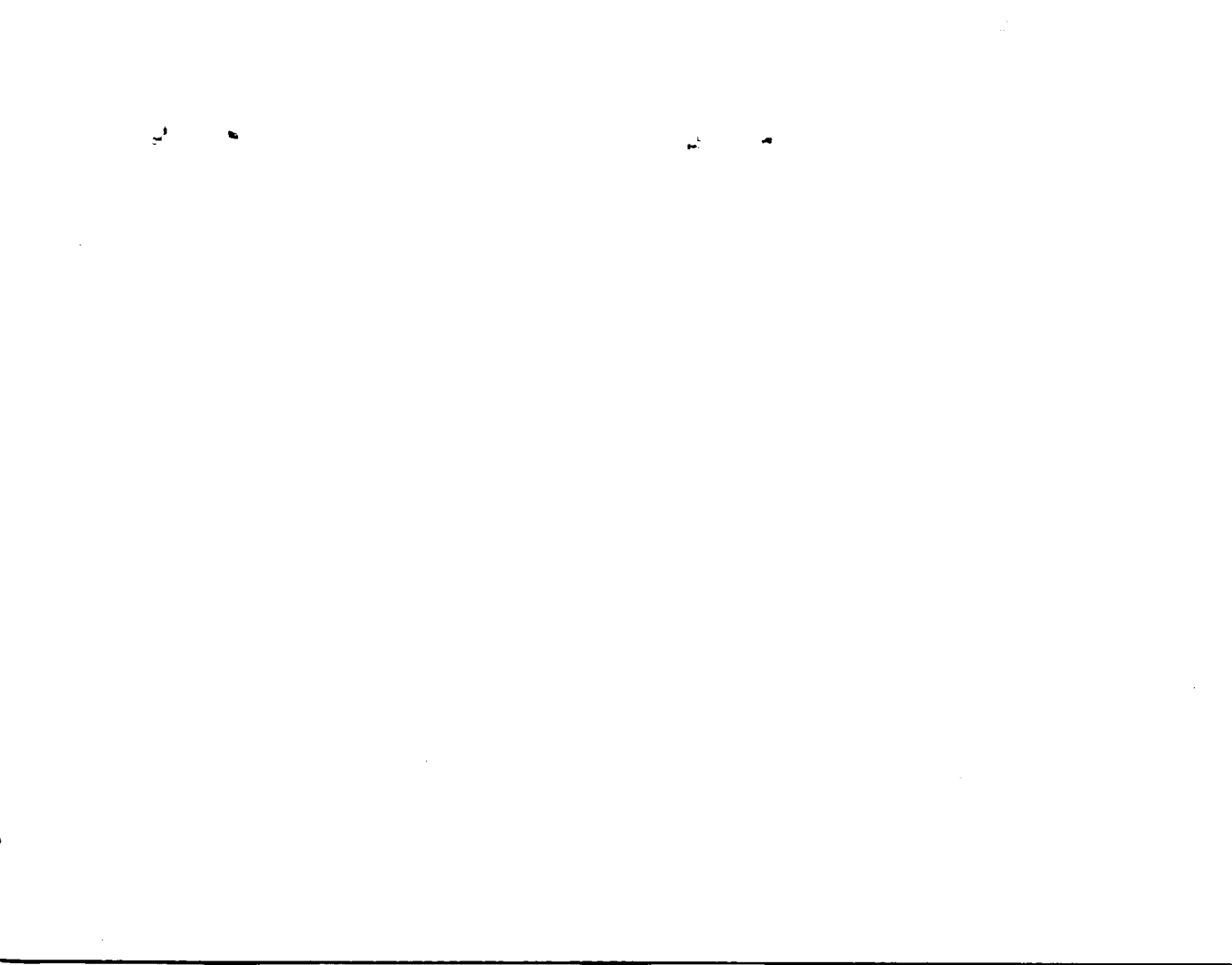
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 7:00 P M.
on the date above stated.

(Signature) W. Beck

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Blackfoot, Ida
Filed Sept 2 1928 Malcolm E. Lohrie
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 10 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

62731

State File No.

Local Registrar's No. 122

PLACE OF DEATH

County of BinghamRegistration District No. 121City of PringlePrimary Registration District No. 2194(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Stillborn Atwood

(a) Residence. No.

St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

Stillborn

7 AGE

Years

Months

Days

If LESS than
1 day, ____ hrs.
or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pringle Idaho
(State or country)

10 NAME OF FATHER

Ivan James Atwood11 BIRTHPLACE OF FATHER (city or town)
(State or country)Utah

12 MAIDEN NAME OF MOTHER

Lenora Boyd13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Kentucky

14

Informant

(Address)

Wilbert Atwood
Pringle Idaho

15

Filed

Aug 10 1928
McClister E. Fisher
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Stillborn
Aug 9 19 28
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____.

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Placental InfarctDeaf about 2 weeks
before birth
(duration) ____ yrs. ____ mos. ____ ds.CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
If not at place of death? _____Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. W. Beck, M. D.Aug 9, 19 28 (Address) Blackfoot Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Atwood Farm 8/10 19 28

20. Undertaker

Wilbert Atwood Pringle Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases; the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED SEP 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

164136

County of Bingham
City of Pringree
No. 652221006253 St.

Registration District No. 121 State File No. 2194

Prim. Registration District No. 2194 Local Registrar's No. 323

FULL NAME OF CHILD

Stillborn Webb
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin <input type="checkbox"/> Triplet <input type="checkbox"/> or other? <input type="checkbox"/>	and { Number in order of birth <u>1</u> }	Legitimacy <u>Yes</u>	Date of birth <u>Aug 21</u> 19 <u>28</u>
(To be answered only in event of plural births)			(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum argyrol

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead 1 Stillborn 1

FATHER FULL NAME <u>Alma Webb</u>	MOTHER FULL MAIDEN NAME <u>Coral Kelsey</u>
--------------------------------------	--

Residence (Usual place of abode) Pringree

If nonresident, give place and State

Color or race White Age at last Birthday 32 Color or race White Age at last Birthday 28

Birthplace Utah (Years) Birthplace Utah (City and State or Country)

Occupation Farmer Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 4:00 P M.
on the date above stated.

(Signature) W. W. Beck

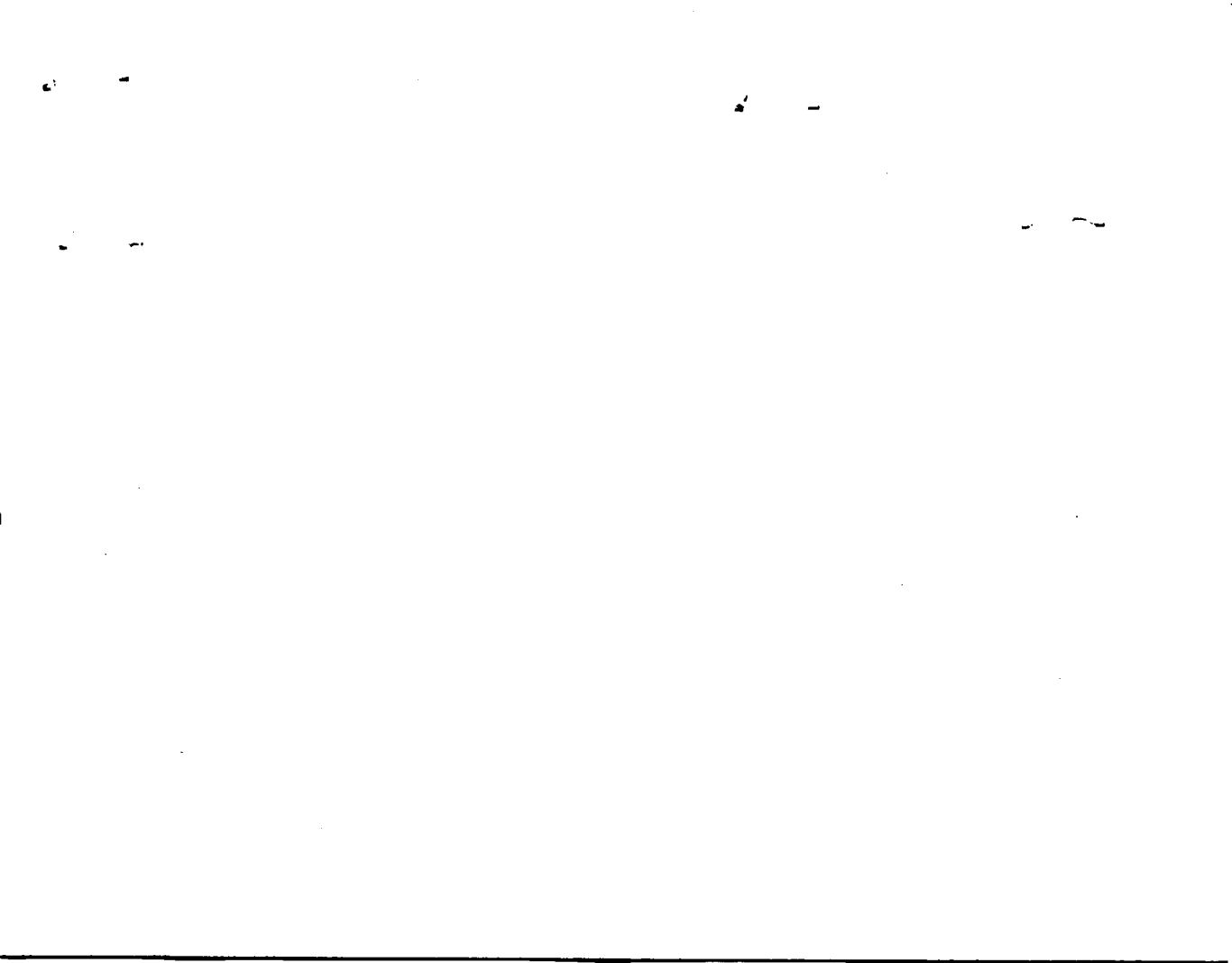
(Physician or midwife)

Address Blackfoot, Idaho

Filed Sept 3 1928 Mrs. Charles E. Latimer

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 10

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

62738

State File No.

Local Registrar's No.

PLACE OF DEATH

County of BinghamCity of Pangua

CERTIFICATE OF DEATH

Registration District No. 121Primary Registration District No. 2194(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Stillborn Webb

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) Aug 2/19287 AGE Stillborn Years _____ Months _____ Days _____
If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Pangua, Idaho

10 NAME OF FATHER

Alma Webb11 BIRTHPLACE OF FATHER (city or town)
(State or country) Utah

12 MAIDEN NAME OF MOTHER

Koral Kelsey13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Utah

14

Informant Alma Webb
(Address) Pangua, Idaho

15

Filed Aug 21 1928by M. C. Waters

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH StillbornAug
(Month)21
(Day)1928
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19_____,

that I last saw him alive on _____, 19_____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Death occurred about
7 weeks before birth
Could not determine
cause (duration) _____ yrs. _____ mos. _____ ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Beck, M. D.8/21, 1928 (Address) Blackfoot, Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Alma Webb Ranch, Pangua Aug 21 192820. Undertaker acting

Address

Alma Webb

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Idaho RECEIVED AUG 20 1928 DEPARTMENT OF PUBLIC WELFARE
City of Carey BUREAU OF VITAL STATISTICS
No. 219-126 0071294 St. 57 CERTIFICATE OF BIRTH
Registration District No. 57 State File No. 164157
(If born in hospital or institution give name.) Prim. Registration District No. 2025 Local Registrar's No. 25

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth 5-26 1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 8 (a) Born alive and now living 6
Born alive but now dead 1 Stillborn 1

FATHER		MOTHER	
FULL NAME	<u>William M. Baird</u>	FULL MAIDEN NAME	<u>Alie Simpson</u>
Residence (Usual place of abode)	<u>Carey, Idaho</u>	Residence (Usual place of abode)	<u>Carey, Idaho</u>
If nonresident, give place and State		If nonresident, give place and State	
Color or race <u>white</u>	Age at last Birthday <u>43</u>	Color or race <u>white</u>	Age at last Birthday <u>40</u>
Birthplace <u>Stebo City, Utah</u>	(City and State or Country)	Birthplace <u>Stebo City, Utah</u>	(City and State or Country)
Occupation <u>farmer</u>		Occupation <u>housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Both alive at 6 P. M. on the date above stated.

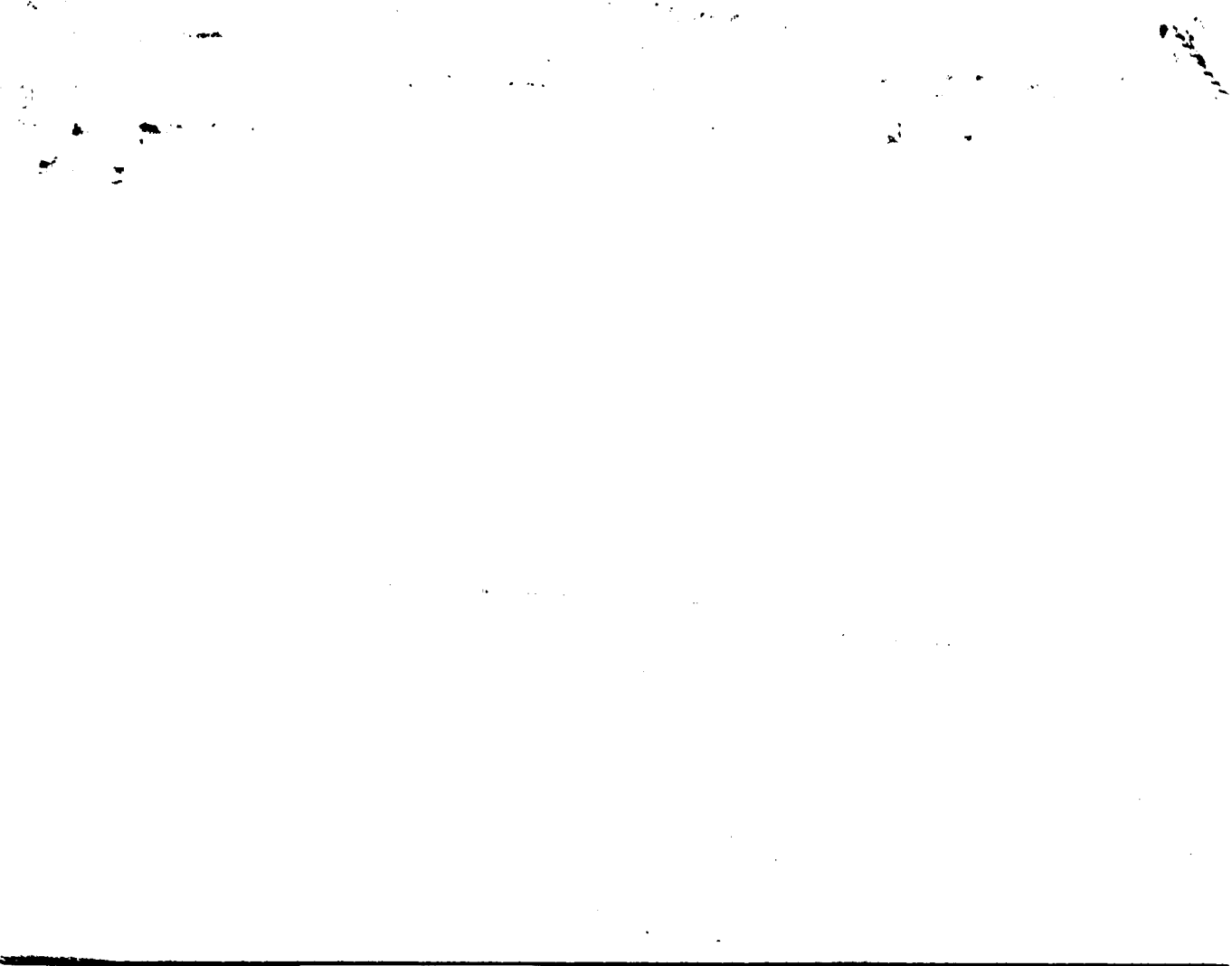
(Signature) [Signature]
Physician
(Physician or midwife)

Address At Carey, Idaho

Filed 6-10 1928 Robert H. Wright

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 18 1928

 STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 62754Local Registrar's No. 32

PLACE OF DEATH

County of BlaineCity of Carey

CERTIFICATE OF DEATH

Registration District No. 57Primary Registration District No. 2045

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stuelborn

(a) Residence. No. _____ St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)

 5a If married, widowed, or divorced
 HUSBAND of
 (or) WIFE of
6 DATE OF BIRTH (month, day and year) 5-26-28

7 AGE Years Months Days If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Carey, Ida
(State or country)10 NAME OF FATHER William M. Baird11 BIRTHPLACE OF FATHER (city or town) Heber City, Ut.
(State or country)12 MAIDEN NAME OF MOTHER Alie Simpson13 BIRTHPLACE OF MOTHER (city or town) Heber City - Ut.
(State or country)
 14 Informant _____
 (Address) _____

 15 Filed 6-10-28 Robert H. Wright
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

5 26 28
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended deceased from 5/26, 1928, to 5-26, 1928, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____Did an operation precede death? no Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) _____

5/26, 1928 (Address) Carey, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Carey, Idaho 5/27 1928

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

RECEIVED SEP 7 1928

PLACE OF BIRTH

STATE OF IDAHO

County of Boone

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of Sandpoint

CERTIFICATE OF BIRTH

No. 753106-009818 St.

Registration District No. 78 State File 161169

(If born in hospital or institution
give name.) Sandpoint Hospital

Prim. Registration District No. 2155 Local Registrar's No.

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>ye</u>	Date of birth <u>Aug 6</u> (Month) (Day) (Year)	<u>1928</u>
--------------------------	---	--------------------------------------	----------------------------	---	-------------

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth (a) Born alive and now living

Born alive but now dead Stillborn

FATHER
FULL NAME Kenneth Pellins

MOTHER
FULL MAIDEN NAME Charlotte Haycock

Residence (Usual place of abode) Sandpoint, Id.

Residence (Usual place of abode) 4th St Sandpoint

If nonresident, give place and State

If nonresident, give place and State

Color or race White Age at last Birthday 32
(Years)

Color or race White Age at last Birthday 28
(Years)

Birthplace Wilkes Barre
(City and State or Country)

Birthplace Wilkes Barre
(City and State or Country)

Occupation Laborer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 4:45 P M.
on the date above stated.

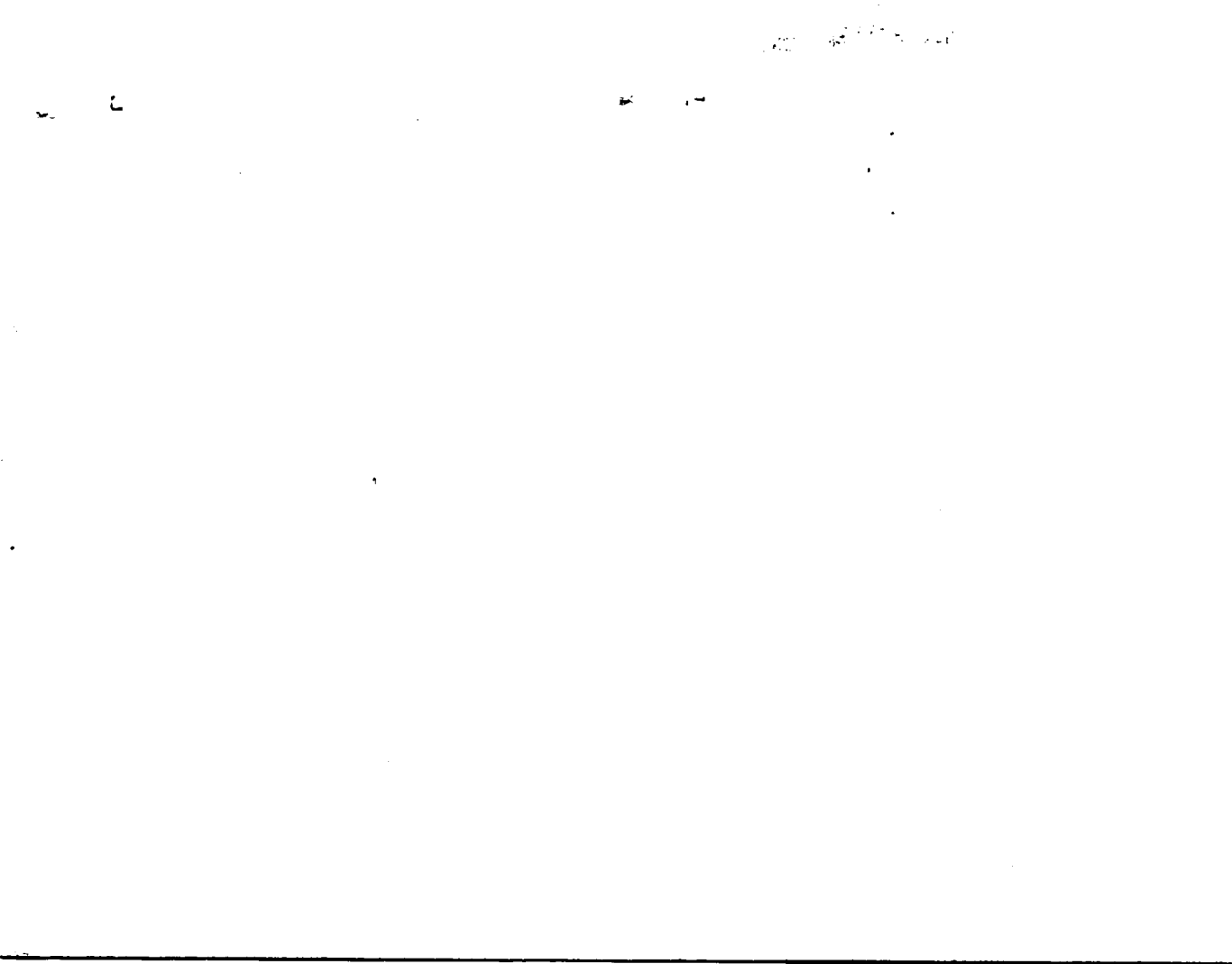
(Signature) Dr. J. C. [Signature]

(Physician or midwife)

Address Sandpoint, Idaho

Filed Sept 4 1928 Viola Allen
Deputy Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1928

PLACE OF DEATH

County of Bonner
City of Sandpoint

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 78
Primary Registration District No. 2155

DO NOT WRITE IN THIS SPACE

State File No. 62761

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

Stillborn Peters

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 6, 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint (State or country) Idaho

10. NAME OF FATHER Kenneth Pellins

11. BIRTHPLACE OF FATHER (city or town) Wilkes Barre (State or Country)

12. MAIDEN NAME OF MOTHER Charlotte Haycock

13. BIRTHPLACE OF MOTHER (city or town) Wilkes Barre (State or Country)

14. Informant Sandpoint Hospital (Address) Sandpoint, Idaho

15. Filed Aug 5, 1928 Nicola Allen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 6th 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY that I attended deceased from

Stillborn, 19

that I last saw him alive on , 19

and that death occurred, on the date stated above, at .m.

The CAUSE OF DEATH* was as follows:

Constricted cord

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Floyd G. Wood M. D.

Aug 5 1928 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Prince of Peace Cemetery Aug 5 1928

20. Undertaker Address

L. H. Moon Sandpoint, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

County of Bonneville DEPT. OF PUBLIC WELFARE
City of Cabaret BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S164188

No. 819 124 009-363 St.

Registration District No. 80 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 1147 Local Registrar's No. 13

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Aug 24</u>	19 <u>28</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 7 (a) Born alive and now living 2

Born alive but now dead Stillborn stillborn

FATHER FULL NAME <u>David D Harris</u> <u>Cabaret</u>	MOTHER FULL MAIDEN NAME <u>Mary J Cochran</u> <u>Cabaret</u>
---	--

Residence (Usual place of abode) Cabaret

If nonresident, give place and State

Color or race Wh Age at last Birthday 32 Color or race Wh Age at last Birthday 31

Birthplace Utah (City and State or Country) Birthplace Wash (City and State or Country)

Occupation Farmer Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 7 a 7 M.
on the date above stated.

(Signature) F O Brady

(Physician or midwife)

Address Clark Fork Idaho

Filed Aug 28 John H. Heston

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

Class Book

Revised (Form) 10-1-67

SECRET

Number of calls in the morning including evening (a) 1000 and now living

[illegible]

(To be answered only in case of special instruction)

1980-1981

(1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100)

County of _____ to wit:
City of _____ to wit:

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF CHILD STATISTICS
CERTIFICATE OF BIRTH

RECEIVED SEP 6 1928

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 80County of BonnerPrimary Registration District No. 2107City of Cabinet

(No. _____ St.)

If death occurs away from home, give the place where death occurred for medical information.

2. FULL NAME

Still birthState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 62755Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

wh.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Aug
(Month)24
(Day)1928
(Year)

7. AGE

Stillbirth
yrs. mos. ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business, or establishment in

which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bonner Co Idaho

10. NAME OF FATHER

David O Harris

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary J Cochran

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

To Bready

(Address)

Charles Fork Idaho

15.

Filed Aug 27 1928John Larson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug
(Month)24
(Day)1928
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191., to

191.,

that I last saw h. alive on 191.,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillbirth

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

To BreadyAug 24 1928 (Address) Charles Fork Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cabinet CemeteryAug 24 1928

20. UNDERTAKER

ADDRESS

none

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.,* *Garcinoma, Sarcoma, etc.,* of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

735 703 014 669
PLACE OF BIRTH

County of Adair
City of Calderwell

No. _____ St. _____

General Hospital
(If born in hospital or institution
give name.)

Registration District No. 3 State File No. 164250
Prim. Registration District No. 2005 Local Registrar's No. 134

FULL NAME OF CHILD stillbirths
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin <u>✓</u> Triplet or other?	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Sept 3</u> (Month) (Day) (Year) <u>1928</u>
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 3 (a) Born alive and now living 1
Born alive but now dead _____ Stillborn 2

FATHER	MOTHER
FULL NAME <u>Roy Glenn</u>	FULL MAIDEN NAME <u>Hazel F. S.</u>

Residence (Usual place or abode) Cambridge, Ida Residence (Usual place or abode) Cambridge, Ida

If nonresident, give place and State _____ If nonresident, give place and State _____

Color or race W. Age at last Birthday 24 Color or race W. Age at last Birthday 23
(Years)

Birthplace Mustale, Ida Birthplace Cambridge, Ida
(City and State or Country) (City and State or Country)

Occupation farmer Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

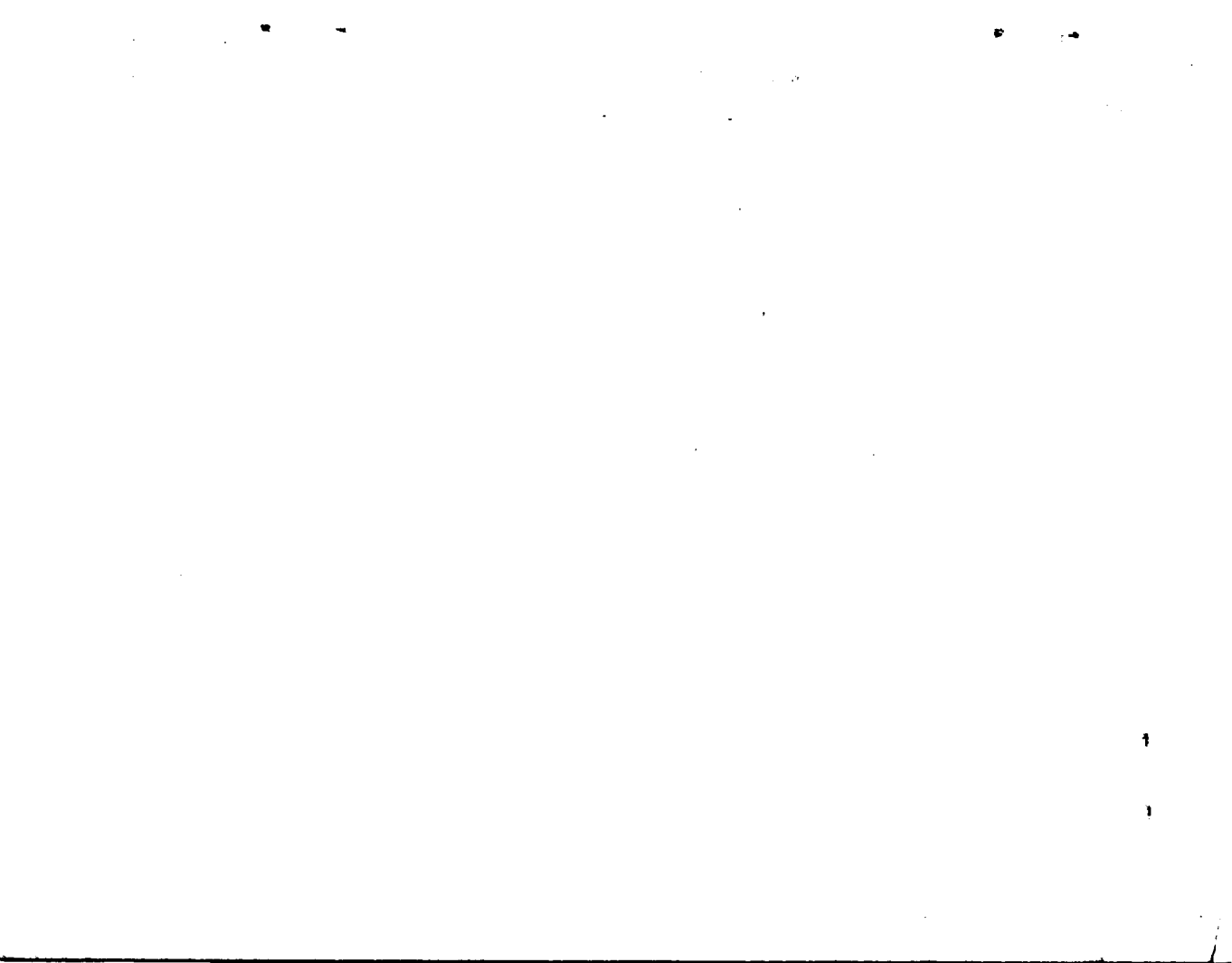
I hereby certify that I attended the birth of this child, who was { Born live } at 3 A. M.
on the date above stated. { Stillborn }

(Signature) W. Montgomery
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Calderwell, Ida

Filed 9-5- 1928 - John S. Hayes
Registrar



RECEIVED SEP 11 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **62778**

PLACE OF DEATH

County of CanyonCity of CaldwellRegistration District No. 3Primary Registration District No. 2005(No. General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 792. FULL NAME Baby Glenn

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
-----------------------	----------------------------------	---

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Sept 4-28

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
--------	-------	--------	------	--

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell Ida
(State or country)10. NAME OF FATHER
Roy Glenn11. BIRTHPLACE OF FATHER (city or town) Fruitvale Idaho
(State or Country)12. MAIDEN NAME OF MOTHER
Hazel M Fuller13. BIRTHPLACE OF MOTHER (city or town) Cambridge Ida
(State or Country)14. Informant Roy Glenn
(Address) Cambridge15. Filed 9-5- 1928 John L. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 4-28

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/3, 1928, to 9/3, 1928that I last saw ~~him~~ alive on 9/3, 1928and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Infantile death

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Montgomery, M. D.9/3, 1928 (Address) Caldwell*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.19. Place of Burial, Cremation, or Removal
Cambridge Ida Date of Burial
9-5-28 1920. Undertaker
Paul L. Case Address
Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF RECEIVED SEP 14 1928

STATE OF IDAHO

County of Clearwater.

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of Orofino, Idaho.

CERTIFICATE OF BIRTH

S

No. 291 108 018 493 St.

Registration District No. 90 State File No. 164303

(If born in hospital or institution
give name.)

Prim. Registration District No. 2168 Local Registrar's No. 78

FULL NAME OF CHILD Not named.

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male.</u>	Twins } and } Triplet } or other? } (To be answered only in event of plural births)	Number in order of birth	Legitimate? <u>Yes.</u>	Date of birth <u>Aug. 8th. 1928</u> (Month) (Day) (Year)
---------------------------	--	--------------------------	-------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 9 (a) Born alive and now living 8

Born alive but now dead none. Stillborn one.

FATHER
FULL NAME J. A. Shaw.

Residence (Usual place of abode) Orofino, Idaho.

If nonresident, give place and State

Color or race White, Age at last Birthday 48
(Years)

Birthplace No.
(City and State or Country)

Occupation Farmer.

MOTHER
FULL MAIDEN NAME Jessie Miller,

Residence (Usual place of abode) Orofino, Idaho.

If nonresident, give place and State

Color or race White, Age at last Birthday 30
(Years)

Birthplace No.
(City and State or Country)

Occupation House Wife.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 9:15 A. M.
on the date above stated.

(Signature) M. F. [illegible]

Physician.
(Physician or midwife)

Address Orofino, Idaho.

Filed Sept. 1st.

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 14 1928

PLACE OF DEATH

County of ClearwaterCity of Orofino

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No.

Primary Registration District No. 2168

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Not Named

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

(If nonresident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. Single, Married, Widowed,
or Divorced (write the word)Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Aug 8 1928

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work None(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Orofino Id
(State or country)

10. NAME OF FATHER

J.A. Shaw11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Missouri

12. MAIDEN NAME OF MOTHER

Jesse Miller13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Missouri14. Informant J.A. Shaw

(Address)

Orofino Id15. Filed Aug 8 1928

Registrar

DO NOT WRITE IN THIS SPACE

State File No. 62805Local Registrar's No. 51

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug8

19

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 8 1928, to Aug 8 1928that I last saw him alive on Aug 8 1928

and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* was as follows:

Unknown - Died several days before birth.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? noDid an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? Physical exams

(Signed)

Aug 8 1928 (Address) Orofino Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Orofino IdAug 8

19

20. Undertaker

Address

J.A. Shaw Orofino

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF RECEIVED SEP 7 1928
Franklin

STATE OF IDAHO

S

County of _____

City of Clifton

No. 2 St.

852-211021-866

(If born in hospital or institution
give name.)

Registration District No. 27 State File No. 164332

Prim. Registration District No. 2119 Local Registrar's No. 183

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth (To be answered only in event of plural births)	Legitimacy mate? <u>es</u>	Date of birth <u>Aug. 11,</u> 19 <u>28</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? 20 % Ag.

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME Glyde Hess

Residence (Usual place of abode) Clifton, Idaho

If nonresident, give place and State _____

Color or race White Age at last Birthday 26

Birthplace Utah (Years)

Occupation Mine Foreman (City and State or Country)

MOTHER
FULL MAIDEN NAME Arvilla Hooker

Residence (Usual place of abode) Clifton, Idaho

If nonresident, give place and State _____

Color or race White Age at last Birthday 27

Birthplace Idaho (Years)

Occupation Housewife (City and State or Country)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 1:15 P. M.
on the date above stated.

(Signature) A. R. Ceiler
Physician

(Physician or midwife)

Address Preston, Idaho

Filed Sept. 4, 1928 A. R. Ceiler

Registrar

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

show other evidence of the child's
child is one that neither brother nor
etc., should make this return. A child
or midwife, then the father, householder,
'Where there was no attending physician

Physician

Presented by

85 4 1402

1. CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

നാഷണലിസം

100-443887-10

UNCLASSIFIED

100

100-443887-100

50

Residence (Usual place of abode) Canton, Idaho

Refractive (usual place of speech) Division, 1910-1911

HERTZ

SENTOL

Bush won 200 with a nod

14-00000

What prophylactic was used to prevent cephalitis meningitis?

50 4

6/10/83

SECRET

1000

[illegible]

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to 1941

11,344

UNRECORDED COPY

12

DECLASSIFICATION OF BIRTH

BUREAU OF VITAL STATISTICS
DEPARTMENT OF PUBLIC HEALTH

OHADI TO STATE

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 62810

PLACE OF DEATH
County of Franklin
City of Clifton

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No. 29

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Hess

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Female	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year)		
7. AGE Years 0	Months 0	Days 0
If LESS than 1 day, 0 hrs. or 0 min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) Clifton, Idaho
(State or country)

10. NAME OF FATHER Clyde Hess
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Orville Hooker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Mrs. Clyde Hess
(Address) Clifton, Idaho

15. Filed Sept 4, 1928 R. R. Curley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. 11, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
_____, 19____, to _____, 19____
that I last saw h_____ alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Peripartum
Stillborn
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis?
(Signed) _____ M. D.
9/12, 1928 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal
Clifton, Idaho
Date of Burial
19

20. Undertaker
Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), 29 ds.; **Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH **Franklin** **RECEIVED SEP 7 1928** STATE OF IDAHO
County of _____ DEPARTMENT OF PUBLIC WELFARE
City of **Franklin** BUREAU OF VITAL STATISTICS
No. _____ St. **S**
629-128-021849 Registration District No. **27** State File No. **164338**
(If born in hospital or institution give name.) Prim. Registration District No. **2119** Local Registrar's No. **190**

FULL NAME OF CHILD _____
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male	Twin Triplet or other? _____	and { Number in order of birth _____ }	Legitimate? Yes	Date of birth Aug. 28 1928
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? **20 % Ag.**

Number of child of this mother, including present birth **1** (a) Born alive and now living **1**
Born alive but now dead _____ Stillborn _____

FATHER	MOTHER
FULL NAME Clifford Whitehead	FULL MAIDEN NAME Gwen Hurd
Residence (Usual place of abode) Franklin, Idaho	Residence (Usual place of abode) Franklin, Idaho
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race White 24 Age at last Birthday 24	Color or race White 21 Age at last Birthday 21
Birthplace Idaho (City and State or Country)	Birthplace Idaho (City and State or Country)
Occupation Farming	Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was **Born alive** at **11:30 A.** M.
on the date above stated.

(Signature) **P. R. Cuel**

Physician
(Physician or midwife)

Address **Preston, Idaho**

Filed **Sept. 4 1928**

P. R. Cuel
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

THIS IS A STATEMENT OF THE FACTS OF THE BIRTH OF THE CHILD OF THE NAME OF THE CHILD AS ABOVE STATED. IT IS THE DUTY OF THE REGISTRAR TO RECORD THE BIRTH OF THE CHILD AND TO ISSUE A CERTIFICATE OF BIRTH TO THE PARENTS OF THE CHILD. THE REGISTRAR IS NOT RESPONSIBLE FOR THE TRUTH OR ACCURACY OF THE STATEMENT OF THE FACTS OF THE BIRTH OF THE CHILD AS ABOVE STATED. THE REGISTRAR IS NOT RESPONSIBLE FOR THE TRUTH OR ACCURACY OF THE STATEMENT OF THE FACTS OF THE BIRTH OF THE CHILD AS ABOVE STATED.

Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

(Signature)

Physician

Preston, Idaho

Filed Sept. 4 1928

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

At 11:30 A. M.

Residence (Town and State or County) **Idaho**

Color or race **White**

Is nonresident, give place and State **Idaho**

Residence (Usual place of abode) **Franklin, Idaho**

Each after but now dead **I**

What prophylactic was used to prevent (tetanoid neonatorum) **No & 28**

Sex of Child **Male**

Full Name of Child **Franklin**

City of **Franklin**

State of **Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instruction on back of certificate.

RECEIVED SEP 7 1928
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
PLACE OF DEATH
County of Franklin
City of Franklin
Registration District No. 27
Primary Registration District No. 2119

DO NOT WRITE IN THIS SPACE

State File No. 62811Local Registrar's No. 38

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Whithead

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE Years 0 Months 0 Days 0 If LESS than 1 day, 0 hrs. or 0 min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Franklin, Idaho
(State or country)

10. NAME OF FATHER Clifford, Whitehead

11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Mrs. Hurd

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Clifford Whitehead
(Address) Franklin, Idaho

15. Filed Sept 4, 19 28 A.P. Chubb
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 28, 1928

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A.P. Chubb M. D.
8/29, 19..... (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Franklin, Idaho
Date of Burial 19

20. Undertaker
Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

County of TERRELL

City of Ferdinand

No.

St.

293.120.025-863

(If born in hospital or institution give name.)

Registration District No. 105

State File No. 164402

Prim. Registration District No. 2183

Local Registrar's No. 37

FULL NAME OF CHILD Adrian Peter Bicker (Steebisch)

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child M.

Twin
Triplet
or other?

and { Number
in order
of birth

Legiti-
mate? yes

Date of
birth July 20

1928
(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3

(a) Born alive and now living 2

Born alive but now dead

Stillborn 1

FULL
NAME Frank H. Bicker

FATHER

FULL
MAIDEN
NAME Loretta Hochmeyer

MOTHER

Residence (Usual place of abode) Ferdinand

Residence (Usual place of abode) Ferdinand

If nonresident, give place and State

If nonresident, give place and State

Color or race W.

Age at last Birthday 32

(Years)

Color or race W.

Age at last Birthday 25

(Years)

Birthplace St. Anthony, Ind.

(City and State or Country)

Birthplace St. Anthony, Ind.

(City and State or Country)

Occupation Farming

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn on the date above stated.

2:45 P. M.

(Signature) R. V. Dunlap

(Physician or midwife)

Address Craigmont, Ida

Filed Aug 31

1928

H. F. Orr Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1. Name of child
 2. Sex of child
 3. Date of birth
 4. Place of birth
 5. Name of mother
 6. Name of father
 7. Name of attending physician or midwife
 8. Address of child
 9. Address of mother
 10. Address of father
 11. Address of attending physician or midwife
 12. Address of child's home
 13. Address of child's school
 14. Address of child's church
 15. Address of child's synagogue
 16. Address of child's mosque
 17. Address of child's temple
 18. Address of child's other place of worship
 19. Address of child's other place of interest
 20. Address of child's other place of residence
 21. Address of child's other place of business
 22. Address of child's other place of employment
 23. Address of child's other place of education
 24. Address of child's other place of recreation
 25. Address of child's other place of travel
 26. Address of child's other place of contact
 27. Address of child's other place of communication
 28. Address of child's other place of information
 29. Address of child's other place of entertainment
 30. Address of child's other place of amusement
 31. Address of child's other place of relaxation
 32. Address of child's other place of rest
 33. Address of child's other place of sleep
 34. Address of child's other place of food
 35. Address of child's other place of drink
 36. Address of child's other place of clothing
 37. Address of child's other place of grooming
 38. Address of child's other place of hygiene
 39. Address of child's other place of health
 40. Address of child's other place of medicine
 41. Address of child's other place of surgery
 42. Address of child's other place of treatment
 43. Address of child's other place of care
 44. Address of child's other place of protection
 45. Address of child's other place of defense
 46. Address of child's other place of attack
 47. Address of child's other place of escape
 48. Address of child's other place of refuge
 49. Address of child's other place of shelter
 50. Address of child's other place of cover
 51. Address of child's other place of concealment
 52. Address of child's other place of hiding
 53. Address of child's other place of secret
 54. Address of child's other place of mystery
 55. Address of child's other place of intrigue
 56. Address of child's other place of conspiracy
 57. Address of child's other place of collusion
 58. Address of child's other place of agreement
 59. Address of child's other place of understanding
 60. Address of child's other place of knowledge
 61. Address of child's other place of wisdom
 62. Address of child's other place of insight
 63. Address of child's other place of perception
 64. Address of child's other place of observation
 65. Address of child's other place of attention
 66. Address of child's other place of concentration
 67. Address of child's other place of focus
 68. Address of child's other place of interest
 69. Address of child's other place of concern
 70. Address of child's other place of care
 71. Address of child's other place of protection
 72. Address of child's other place of defense
 73. Address of child's other place of attack
 74. Address of child's other place of escape
 75. Address of child's other place of refuge
 76. Address of child's other place of shelter
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 93. Address of child's other place of concentration
 94. Address of child's other place of focus
 95. Address of child's other place of interest
 96. Address of child's other place of concern
 97. Address of child's other place of care
 98. Address of child's other place of protection
 99. Address of child's other place of defense
 100. Address of child's other place of attack

CHILD NAME OF CHILD

Sex of child	Age of child	Date of birth	Place of birth

Is the child now living? (a) Yes (b) No

MOTHER	FATHER

Is the child now living? (a) Yes (b) No

Color of hair	Color of eyes

Is the child now living? (a) Yes (b) No

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was (Name) at (Address) on (Date)

(Signature)

(Address of physician or midwife)

Address

Filed

There were no attending physician or midwife, then the father, considered etc, should make this return. A child is one that neither physician nor nurse ever attended at the birth.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 10 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 62835

PLACE OF DEATH

County of Idaho
City of Ferdinand

CERTIFICATE OF DEATH

Registration District No. 105
Primary Registration District No. 2183
(No. _____)

Local Registrar's No. 11

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Adrian Peter Bieker

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) July 20, 1928

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED Stillborn
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Ferdinand Idaho
(State or country)

10 NAME OF FATHER Frank H Bieker

11 BIRTHPLACE OF FATHER (city or town) St Anthony Ind
(State or country)

12 MAIDEN NAME OF MOTHER

Loretta Hochgesang
13 BIRTHPLACE OF MOTHER (city or town) St Anthony Ind
(State or country)

14 Informant X Frank H Bieker
(Address) Ferdinand Idaho

15 Filed Aug 31, 1928 At 7 Pm per J.B.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 20 28
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1928, to July 20, 1928, that I last saw him alive on July 20, 28, and that death occurred, on the date stated above, at 2.30 P

The CAUSE OF DEATH* was as follows:
Stillborn

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted _____
If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) R. B. Smith, M. D.
7-23-1928 (Address) Freightmont Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Ferdinand, Ida. Date of Burial 7-23 1928
20. Undertaker Ferdinand Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED SEP 10 1928

STATE OF IDAHO

County of Idaho
City of Patterson

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

No. _____ St. _____

412-116 DS-547

(If born in hospital or institution
give name.)

Registration District No. 105 State File No. 164407

Prim. Registration District No. 2183 Local Registrar's No. 42

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	<input checked="" type="checkbox"/> Twin <input checked="" type="checkbox"/> Triplet or other?	and {	Number in order of birth <u>7th</u>	Legitimate? <u>Yes</u>	Date of birth <u>Aug 16</u> 19 <u>28</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? -

Number of child of this mother, including present birth 7 (a) Born alive and now living 5

Born alive but now dead _____ Stillborn Yes 2

FATHER
FULL NAME Edward Desunbeck

MOTHER
FULL MAIDEN NAME Rose Russell

Residence (Usual place of abode) Patterson

If nonresident, give place and State _____

Color or race White Age at last Birthday 34 (Years)

Birthplace Edgingham Ill. (City and State or Country)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at S. A. M.
on the date above stated.

(Signature) Neely F. Orr

(Physician or midwife)

Address Patterson, Idaho

Filed Aug 31 1928 H. F. Orr Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

FORM V. S. No. 5-

RECEIVED SEP 10 1928

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Idaho*
City of *Patterson*Registration District No. *105*
Primary Registration District No. *2183*
(No. _____ St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *62837*
Registered No. *13*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Dusenbrook

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)6. DATE OF BIRTH *Aug 16 1928*
(Month) (Day) (Year)

7. AGE _____ Yrs. _____ Mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)9. BIRTHPLACE
(State or Country) *Patterson Id.*10. NAME OF FATHER *Edward Dusenbrook*11. BIRTHPLACE OF FATHER
(State or Country) *Id.*12. MAIDEN NAME OF MOTHER *Rose Murrell*13. BIRTHPLACE OF MOTHER
(State or Country) *Idaho*14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Edward Dusenbrook*
(Address) *Patterson Id.*15. Filed *Aug 31 1928* *H. F. Am.*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug 16 1928*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____, that I last saw him _____ alive on _____ 19____, and that death occurred on the date stated above, at *8 A. M.*The CAUSE OF DEATH* was as follows:
*Pregnancy complicated by perforated appendicitis of mother.*_____. (Duration) _____ Yrs. _____ mos. _____ ds.
Contributory (Secondary) __________. (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *Avery F. Orr* M. D.
8/16 1928 (Address) *Patterson Id.*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Cheney, Idaho* DATE OF BURIAL *Aug 16 1928*20. ADDRESS *Father Dusenbrook, Cheney, Idaho*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

493124 09 243
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

164442

RECEIVED AUG 22 1928
County of Latah

City of Julietta

No. _____ St. _____

Registration District No. 63

File No. _____

Hospital at home

Primary Registration District No. _____

Registered No. _____

FULL NAME OF CHILD

Baby Millard

(Certificate of no value without full name of child.)

Sex of Child

Male

Twin
Triplet
or other

No

and

Number
in order
of birth

—

Legiti-
mate?

Yes

Date of
birth.

June 24, 1928
(Month) (Day) (Year)

What bacteriocidal solution was used in eyes?

None - steelbach

Number of child of this mother, including present birth

2

Number of child of this mother now living, including present birth

1

FULL
NAME

FLOYD MILLARD

FULL
MAIDEN
NAME

IRVING F. BULLEN

RESIDENCE

Julietta, Ida

RESIDENCE

Julietta, Ida

COLOR

W

AGE AT LAST
BIRTHDAY

24
(Years)

COLOR

W

AGE AT LAST
BIRTHDAY

22
(Years)

BIRTHPLACE

Julietta, Ida

BIRTHPLACE

Lewiston, Ida

OCCUPATION

P.R. Tech. labor

OCCUPATION

Hof.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born on the date above stated.

stillborn

9:30 A. M.
(Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

Oliver Moorehead

Physician
(Physician or midwife)

Give names added from a supplemental report.

Address

Tendrick, Ida

Filed

Aug 10 1928

B. F. Nesbit

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of SIOUX
City of Burke

No. _____ St. _____

294-019-040-795

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 164569

Registration District No. 70 State File No. _____

Prim. Registration District No. 1011 Local Registrar's No. 76

FULL NAME OF CHILD Stillborn - Premature

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Stillborn</u>	Twin <u>Triplet</u> or other? <u>No</u>	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>August 19, 1928</u>
<u>4 1/2 mos</u>	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth None (a) Born alive and now living None

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME Theo. Simonson

Residence (Usual place of abode) Burke, Idaho

If nonresident, give place and State _____

Color or race White Age at last Birthday 25

Birthplace South Dakota (Years)

(City and State or Country)

Occupation Blacksmith

MOTHER
FULL MAIDEN NAME Margaret Green

Residence (Usual place of abode) Burke, Idaho

If nonresident, give place and State _____

Color or race White Age at last Birthday 22

Birthplace Sweden (Years)

(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn M.
on the date above stated.

(Signature) [Signature]

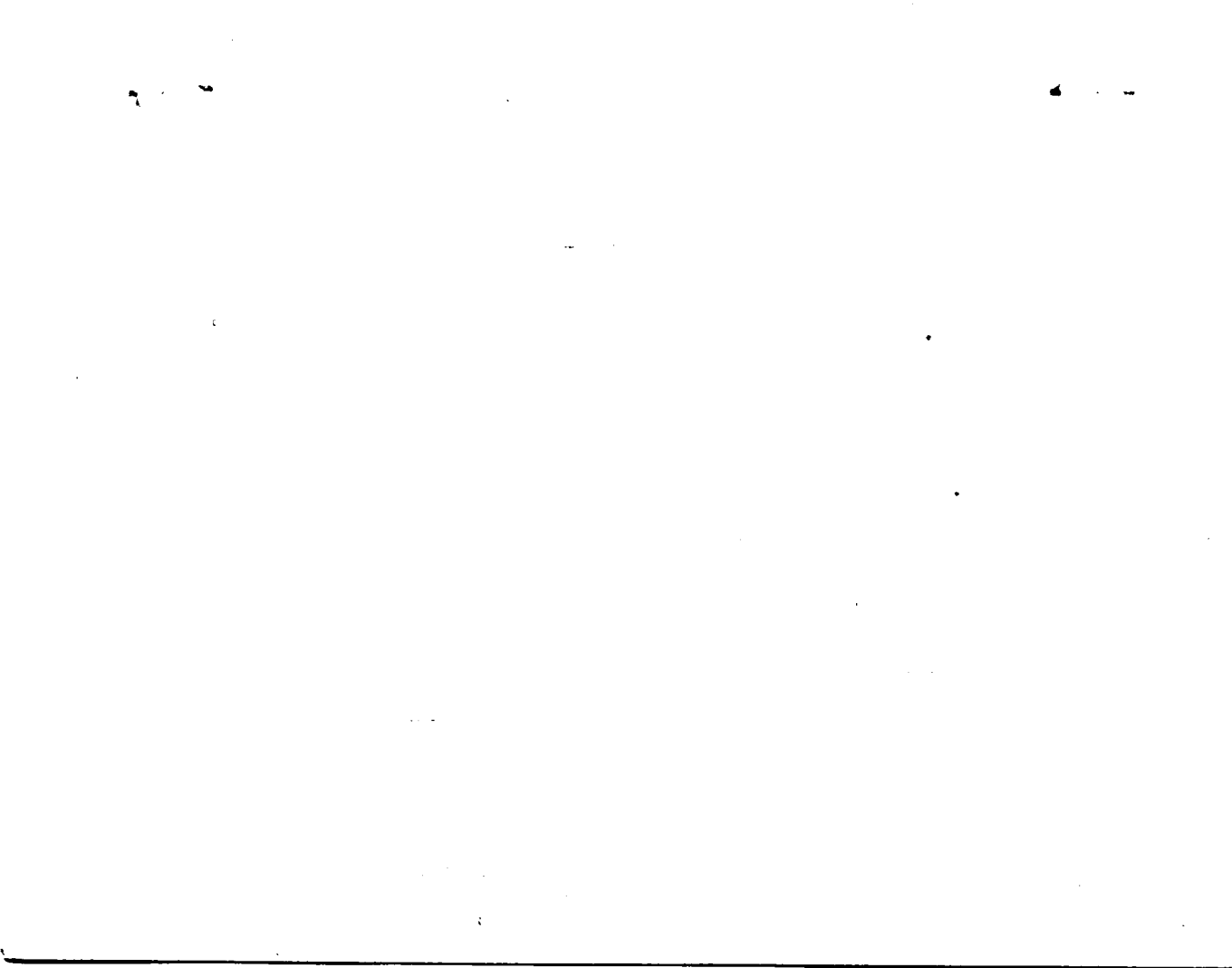
(Physician or midwife)

Address Wallace, Idaho

Filed Aug 20, 1928

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 1 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

-DO NOT WRITE IN THIS SPACE

PLACE OF DEATH

CERTIFICATE OF DEATH

State File No. 68516

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 290

(No. St. Alphonsus Hos)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Danielle

(a) Residence. No. St. Gardiner, Ida

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OF RACE White 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 27 - 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still Born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Ida
(State or country)

10. NAME OF FATHER Arley Danielle

11. BIRTHPLACE OF FATHER (city or town) Mo.
(State or Country)

12. MAIDEN NAME OF MOTHER Edna Lee

13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)14. Informant Arley & Danielle
(Address) Gardiner, Idaho

15. Filed 11/14/28 Paula McDonaugh

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 27th 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 27, 1928, to October 27, 1928, that I last saw him on October 27, 1928, and that death occurred, on the date stated above, at min.

The CAUSE OF DEATH* was as follows:

Detached placenta
much hemorrhage
about 3 1/2 days before birth.
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)English mouth petis
(duration) yrs. mos. ds.18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Bouch M. D.

October 27, 1928 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Morris Hill Cemetery Oct 28 1928

20. Undertaker Address

Schmidt & W. Evans Boise, Ida

Dr. John Brock.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

County of Twiss Falls
City of Twiss FallsDEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

No. 555-228-042-313 St.Registration District No. 39 State File No. 164590(If born in hospital or institution
give name.)Prim. Registration District No. 2087 Local Registrar's No. 2

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>4</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>Aug 26</u> 19 <u>28</u> (Month) (Day) (Year)
-----------------------	---	--	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living None

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME H. O. Everett
Residence (Usual place of abode) Twiss FallsMOTHER
FULL MAIDEN NAME Jessie Calton
Residence (Usual place of abode) Twiss Falls

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race W. Age at last Birthday 19 (Years)Color or race W. Age at last Birthday 33 (Years)Birthplace Mo. (City and State or Country)Birthplace Mo. (City and State or Country)Occupation FarmerOccupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7:20 a M.
on the date above stated.(Signature) J. H. Murphy

(Physician or midwife)

Address Buhl, IdaFiled 8-28 1928 J. H. Murphy Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

2. 1

2. 1

RECEIVED SEP 8 1928
PLACE OF DEATHSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 62907

County of *Miner Falls*City of *Buhl*Registration District No. *39*Primary Registration District No. *2087*

Local Registrar's No. _____

(If death occurred in a hospital or institution, give the name instead of street and number.)

2. FULL NAME *Baby Everett (Bluehorn)*

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. *X* yrs. *X* mos. *X* ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*4. COLOR OR RACE *White*5. Single, Married, Widowed, or Divorced (write the word) *Single*5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6. DATE OF BIRTH (month, day and year) *Aug 26th 1928*

7. AGE

Years

Months

Days

If LESS than 1 day,

_____ hrs. or
_____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) *Buhl Ida*
(State or country)10. NAME OF FATHER *H.O. Everett*11. BIRTHPLACE OF FATHER (city or town) *Missouri*
(State or Country)12. MAIDEN NAME OF MOTHER *Jessie Colton*13. BIRTHPLACE OF MOTHER (city or town) *Missouri*
(State or Country)14. Informant *H.O. Everett*(Address) *Buhl Ida*15. Filed *Aug 26, 1928*

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug 26th 1928*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 26, 1928, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

*Still born*CONTRIBUTORY (Secondary) *No apparent cause*
(duration) _____ yrs. _____ mos. _____ ds.18. Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) *J. H. Murphy*, M. D.*Aug. 26, 1928* (Address) *Buhl Ida*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *Buhl Ida*Date of Burial *8/26 1928*20. Undertaker *J. Johnson*Address *Buhl*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

297.228 001 194
PLACE OF BIRTH

County of Adair

City of Basis

No. 1520 Jefferson St.

St. Lukes Hospital
(If born in hospital or institution
give name.)

Registration District No. 2 State File No. 164653

Prim. Registration District No. 1004 Local Registrar's No. 313

FULL NAME OF CHILD Stillborn

(If stillborn substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	Number and in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>8 - 28 - 1928</u> (Month) (Day) (Year)
----------------------------	---	------------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? Silver Nitrate

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead none Stillborn 2

FATHER FULL NAME <u>Robt. Harold Fisher</u>	FULL MAIDEN NAME <u>Helen Armstrong</u>
--	---

Residence (Usual place of abode) 1520 Jefferson St.

If nonresident, give place and State

Color or race white Age at last Birthday 47
(Years)

Birthplace West. Va.
(City and State or Country)

Occupation Photographer

If nonresident, give place and State

Color or race white Age at last Birthday 57
(Years)

Birthplace Pa.
(City and State or Country)

Occupation House Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive
on the date above stated. Stillborn at 12:45 A. M.

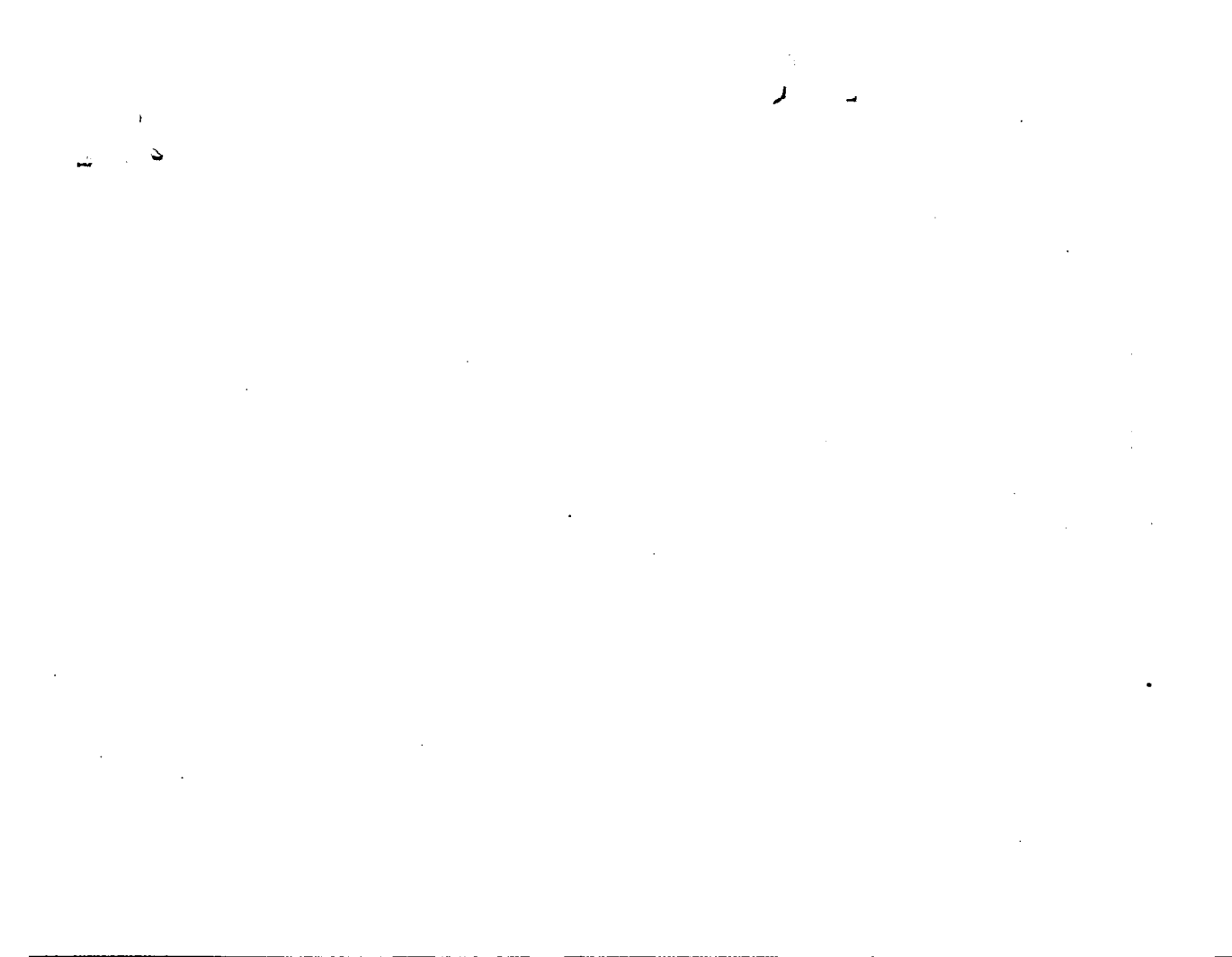
(Signature) Dr. J. Carl Hill

(Physician or midwife)

Address 415 Eastman Bldg.

Filed 9/5/1928 Paula M. Brown
Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



RECEIVED SEP 12 1928

PLACE OF DEATH

County of Ada
City of BoiseSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 2Primary Registration District No. 1904(No. St. Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 62648Local Registrar's No. 219

2. FULL NAME

(a) Residence. No. 1620 W. Jefferson St.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed,
or Divorced (write the word)

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)14. Informant
(Address)

15. Filed

8/24

1928

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19

that I last saw him alive on

19

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

8/29

1928

(Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably such**, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

289-166 201-289
PLACE OF BIRTH
County of Adair RECEIVED OCT 15 1928
City of Baise
No. 1617 224 St.
Salvation Army
(If born in hospital or institution
give name.)
Registration District No. 2 State File No. 164655
Prim. Registration District No. 100 Local Registrar's No. 341
FULL NAME OF CHILD Kenneth Richard Shinn
(If stillborn, substitute the word "Stillborn" for name of child)
Sex of Child male Twin Triplet or other? and Number in order of birth 1 Legitimacy no Date of birth 8/16 1928
(To be answered only in event of plural births) (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum?
Number of child of this mother, including present birth 1 (a) Born alive and now living none
Born alive but now dead 1 Stillborn 1
FATHER FULL NAME Frank Wentz FULL MAIDEN NAME C Esther Shinn
Residence (Usual place of abode) Caldwell Idaho Residence (Usual place of abode) Caldwell Idaho
If nonresident, give place and State
Color or race white Age at last Birthday 20 Color or race white Age at last Birthday 21
(Years) (Years)
Birthplace Idaho Birthplace Moscow Idaho
(City and State or Country) (City and State or Country)
Occupation School Student Occupation School Student

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive 3 P M.
on the date above stated. Stillborn at

(Signature) S. Somneyard

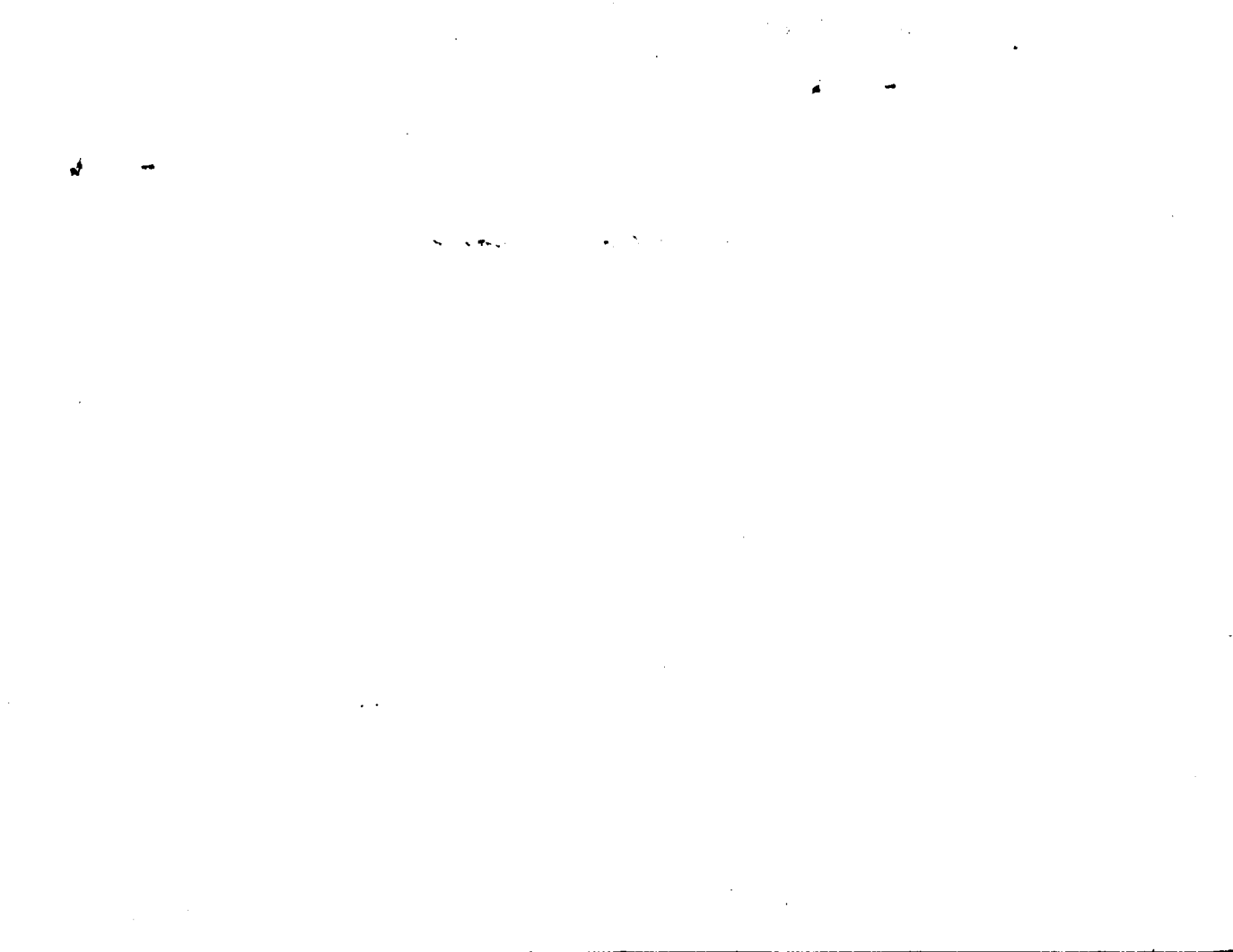
(Physician or midwife)

Address 9/24/28

Filed Paula M. Bond

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 15 1928

PLACE OF DEATH

County of Ada.

City of Boise.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. Salvation Army Rescue Home.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kenneth Richard Shinn.

(a) Residence. No. Boise, Idaho. St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male.

4. COLOR OR RACE

White.

5. Single, Married, Widowed, or Divorced (write the word)

Single.

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 16th 1928.

7. AGE

Years

Months

Days

If LESS than 1 day,
hrs. or
min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

10. NAME OF FATHER

Frank Wentz.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Don't Know.

12. MAIDEN NAME OF MOTHER Ethel Shinn.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Moscow, Idaho.

14. Informant Wm. McBratney.

(Address) Boise, Idaho.

15. Filed 8/16/28 19 28 Wm. McBratney
Registrar

DO NOT WRITE IN THIS SPACE

State File No. 62926

Local Registrar's No. 229

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 16th 1928

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/16/28, 19 28, to 8-16-28, 19 28

that I last saw him alive on 8-16, 19 28

and that death occurred, on the date stated above, at Boise m.

The CAUSE OF DEATH* was as follows:

Still born.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. Where was disease contracted
If not at place of death? ✓

Did an operation precede death? no Date of 8/16

Was there an autopsy? no

What test confirmed diagnosis

(Signed) Wm. McBratney, M. D.
8/16/28, 19 28 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal
Morris Hill Cemetery.

Date of Burial
8/16/28 19 28

20. Undertaker
Wm. McBratney

(Address)
Boise, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Bonner
City of Sandpoint
No. 437 Pine St.
253-230-0098/5
(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
S 64777

Registration District No. 7-f State File No. _____
Prim. Registration District No. 2155 Local Registrar's No. _____

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>Sept. 30</u> <u>1928</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 3 (a) Born alive and now living 0
Born alive but now dead 1 Stillborn 2

FATHER	MOTHER
FULL NAME <u>D. Ross Kelley</u>	FULL MAIDEN NAME <u>Myrtle Marie Hazen</u>
Residence (Usual place of abode) <u>Elk, Wash</u>	Residence (Usual place of abode) _____
If nonresident, give place and State <u>Elk, Wash</u>	If nonresident, give place and State <u>Elk, Wash.</u>
Color or race <u>white</u> Age at last Birthday <u>32</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>20</u> (Years)
Birthplace <u>Kansas</u> (City and State or Country)	Birthplace <u>Kansas</u> (City and State or Country)
Occupation _____	Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 12:30 A. M.
on the date above stated.

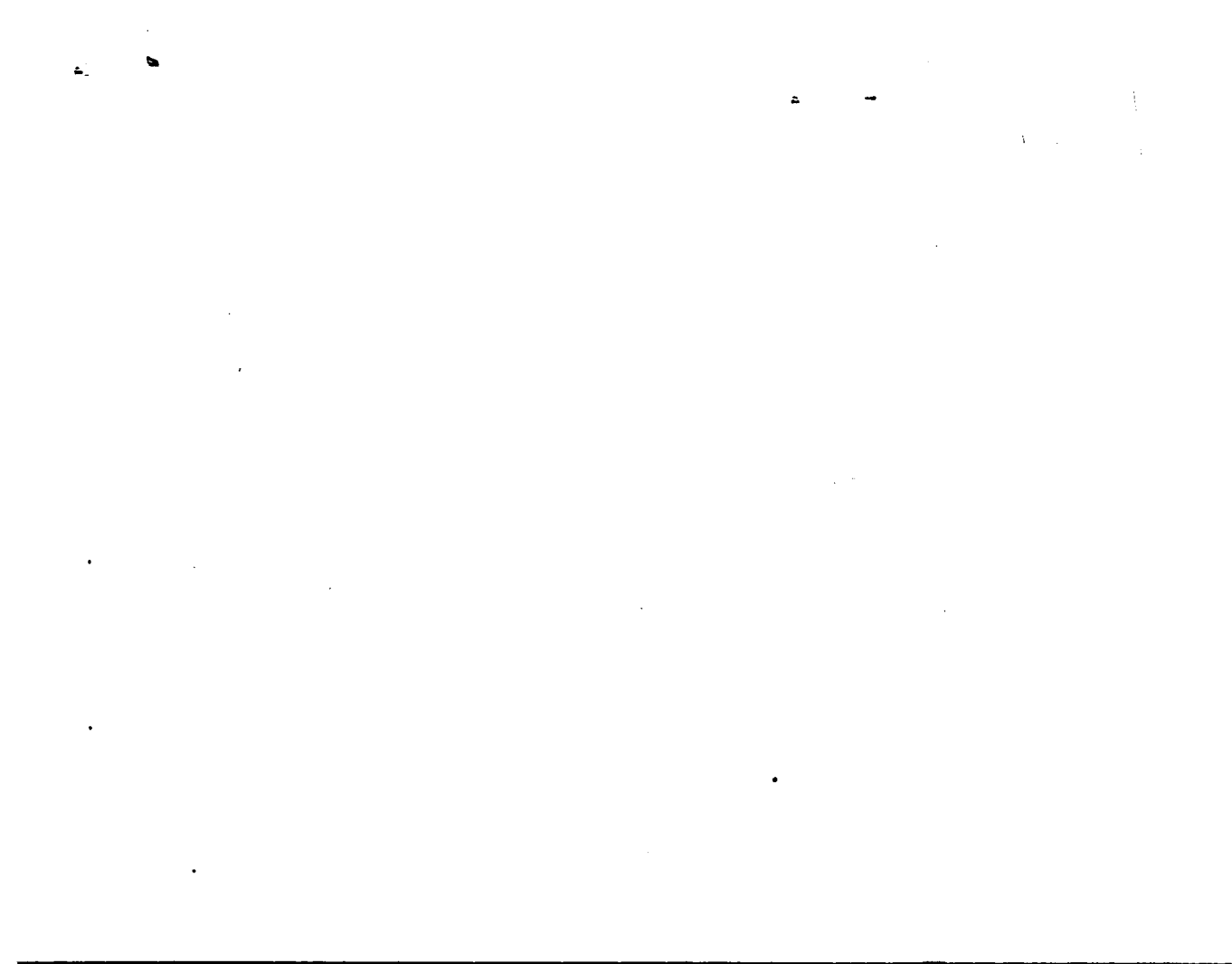
(Signature) G. P. Staehouse

Physician
(Physician or midwife)

Address Sandpoint, Idaho.

Filed 19 Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH **RECEIVED OCT 8 1928**County of **Bonner**City of **Sandpoint**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

CERTIFICATE OF DEATH

Registration District No. **28**Primary Registration District No. **2155**

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **62983**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale White Single
(Write the word)

6. DATE OF BIRTH

Sept. 30 1928
(Month) (Day) (Year)

7. AGE

Mittibitch
Yrs. Mos. ds. IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Oct. 1 1928

Viola Allen
Deputy Local Registrar

16. DATE OF DEATH

Sept 30 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19

that I last saw him alive on 19

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn - Instrumental delivery - free presentation - prolapsed umbilical cord

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. P. Stackhouse M. D.

9-349.28 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pack River Cemetery Sept 30, 1928

20. UNDERTAKER ADDRESS

A. H. Moon Sandpoint, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. **Example: Measles (disease causing death), 20 ds., Bronchopneumonia** (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

154-125032-691
PLACE OF BIRTH

RECEIVED OCT 11 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Sanborn

City of Shoshone

No. _____ St. _____

Registration District No. 16

State File No. 165134

Hospital _____

Primary Registration District No. 16

Local Registrar's No. 33

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child Male

Twin
Triplet
or other?

Number
in order
of birth _____
(To be answered only in event of plural births)

Legiti-
mate? Yes

Date of birth Aug 25 1928
(Month) (Day) (Year)

What bactericidal solution was used in eyes? None.

Number of child of this mother, including present birth 3

Number of child of this mother now living, including present birth 2

FULL
NAME

FATHER

Leodora Anderson

RESIDENCE

Shoshone

COLOR

White

AGE AT LAST
BIRTHDAY 32
(Years)

BIRTHPLACE

Norway

OCCUPATION

Robber

FULL
MAIDEN
NAME

MOTHER

Alice Franklin

RESIDENCE

Shoshone

COLOR

White

AGE AT LAST
BIRTHDAY 21
(Years)

BIRTHPLACE

Washington

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 1 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

(Physician or midwife)

Give names added from a supplemental report.

Address

Chapman 22 1928

Registrar.

Registrar.

16 D

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 13 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 63114

PLACE OF DEATH

County of MadisonRegistration District No. 100City of RexburgPrimary Registration District No. 2178Local Registrar's No. 52

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Hoopes.(a) Residence. No. 206 East Main. St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F. M.

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Babe.

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) Sept. 17, 1928

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.000

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rexburg, Idaho.
(State or country)

10 NAME OF FATHER

George Albert Hoopes.11 BIRTHPLACE OF FATHER (city or town)
(State or country)Idaho.

12 MAIDEN NAME OF MOTHER

Edna Baker.13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Utah.14 Informant Geo. A. Hoopes
(Address) Rexburg, Idaho.15 Filed 10/9 1928 W. J. Young
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

9

(Month)

17

(Day)

1928
(Year)

9-17 HEREBY CERTIFY, That I attended deceased from
1928, to 9-17, 1928
that I last saw her alive on 9-17, 1928
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still bornCONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Wm. J. Young, M. D.9-18, 1928 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Rexburg, Idaho.9/18/28 19

20. Undertaker

Address

W. J. Young Rexburg.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

866-217-033-212

PLACE OF BIRTH

RECEIVED

OCT 13 1928

STATE OF IDAHO

County of Madison

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

City of Rexburg

CERTIFICATE OF BIRTH

No. 1 St. C

Registration District No. 100 State File No. S 165160

(If born in hospital or institution
give name.)

Prim. Registration District No. 2178 Local Registrar's No. 224

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>(To be answered only in event of plural births)</u>	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>9 17 1928</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? Mercuro - Chrome

Number of child of this mother, including present birth 4 (a) Born alive and now living 3

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME George Albert Hoopes

MOTHER
FULL MAIDEN NAME Edna Baker

Residence (Usual place of abode) Rexburg

Residence (Usual place of abode) Rexburg

If nonresident, give place and State ↓

If nonresident, give place and State ↓

Color or race white Age at last Birthday 42
(Years)

Color or race white Age at last Birthday 40
(Years)

Birthplace Idaho
(City and State or Country)

Birthplace Utah
(City and State or Country)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 8:20 P M.
on the date above stated.

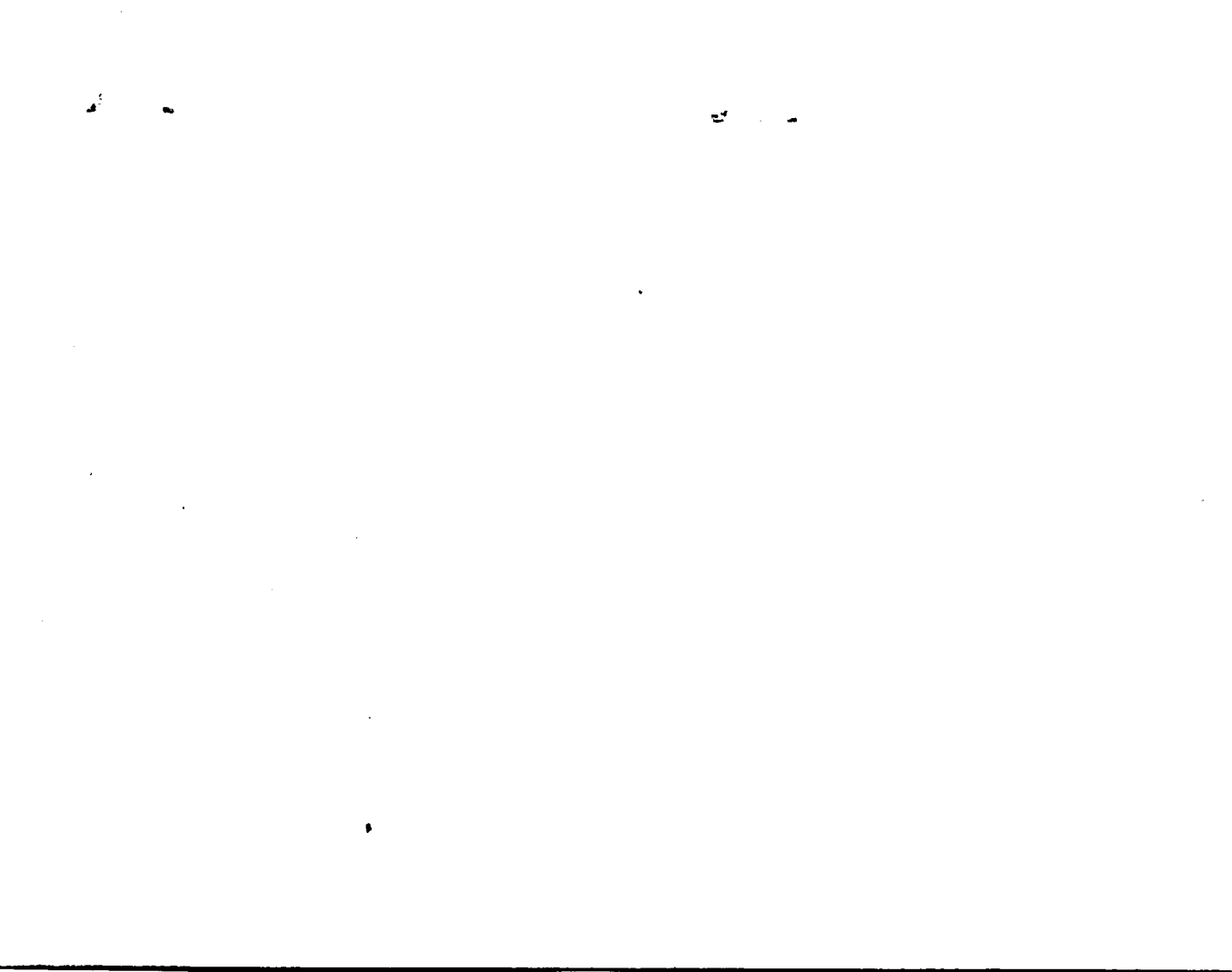
(Signature) Lorin L. Rich

(Physician or midwife)

Address Rexburg Idaho

Filed 10/7 1928 J. R. Young
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



2 2
WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED SEP 22 1928
County of Malden
City of Sugar City
No. 384-227.033-674 (St.)
(If born in hospital or institution give name.)
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
Registration District No. 100 State File No. S 165182
Prim. Registration District No. 2178 Local Registrar's No. Shueson - (Stillborn)

FULL NAME OF CHILD
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and <u> </u>	Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>8 27 1928</u>
(To be answered only in event of plural births)					(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Mercurochrome

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 0

FATHER		MOTHER	
FULL NAME <u>Ray D. Shueson</u>	FULL MAIDEN NAME <u>Mildred Ogden</u>		
Residence (Usual place of abode) <u>Sugar City</u>	Residence (Usual place of abode) <u>Sugar City</u>		
If nonresident, give place and State <u> </u>	If nonresident, give place and State <u> </u>		
Color or race <u>white</u> Age at last Birthday <u>22</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>21</u> (Years)		
Birthplace <u>Idaho</u> (City and State or Country)	Birthplace <u>Idaho</u> (City and State or Country)		
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 8:30 P. M. on the date above stated.

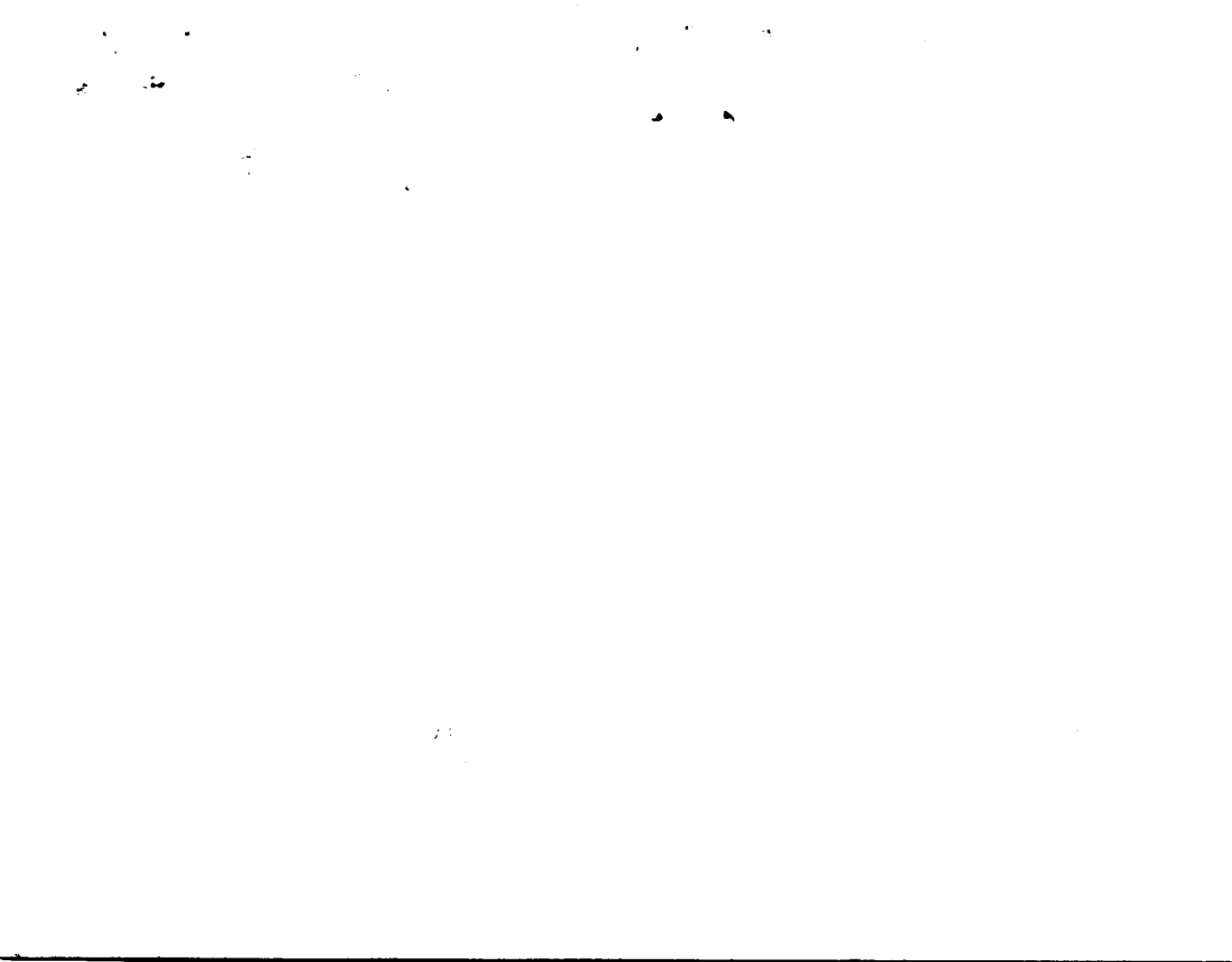
(Signature) Forrest H. Rich

(Physician or midwife)

Address Reeburg, Idaho

Filed 920 19 28 W. Young Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 14 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 62877

County of _____ Registration District No. _____
City of _____ Primary Registration District No. _____
(No. _____)

Local Registrar's No. 48

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Baby Thueson.

(a) Residence. No. Sugar City St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>F. M.</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Pa.</u>
5a If married, widowed, or divorced HUSBAND of (or) WIFE of		
6 DATE OF BIRTH (month, day and year) <u>Aug st 27 1928</u>		
7 AGE Years <u>0</u>	Months <u>0</u>	Days <u>0</u>
If LESS than 1 day, _____ hrs. or _____ min.		
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9 BIRTHPLACE (city or town) <u>Idaho.</u> (State or country)		

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
August 27 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1928, to Aug 27, 1928.
that I last saw h at at home at home, 19____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY maternal factors.
(Secondary) pregnancy 8 months.
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? ✓

Did an operation precede death? ✓ Date of _____

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) John Stueh, M. D.
9-28, 1928 (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Sugar City 8/28/28 19

20. Undertaker Address

W B Eckersell Rexburg,

10 NAME OF FATHER <u>Ray Devine Thueson.</u>
11 BIRTHPLACE OF FATHER (city or town) (State or country) <u>Utah.</u>
12 MAIDEN NAME OF MOTHER <u>Mildred Ogden.</u>
13 BIRTHPLACE OF MOTHER (city or town) (State or country) <u>Utah.</u>
14 Informant <u>Ray Devine Thueson</u> (Address) <u>Sugar City, Idaho.</u>
15 Filed <u>9/10</u> , 19 <u>28</u> <u>J R Young</u> Registrar

PARENTS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

796-111-033-632
PLACE OF BIRTH

County of Madison
City of Archer
No. 2 St.

SEP 22 1926

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

Registration District No. 100 State File No. 165183

Prim. Registration District No. 2178 Local Registrar's No. 200

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Male Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth 8 11 28
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Mercurochrome

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Thomas Marshall Grover
Residence (Usual place of abode) Archer
If nonresident, give place and State ✓
Color or race White Age at last Birthday 23
(Years)
Birthplace Idaho
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Verna Olson
Residence (Usual place of abode) Archer
If nonresident, give place and State ✓
Color or race white Age at last Birthday 24
(Years)
Birthplace Idaho
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was (Born alive) (Stillborn) at 2:30 A. M. on the date above stated.

(Signature) Louise St. Rich

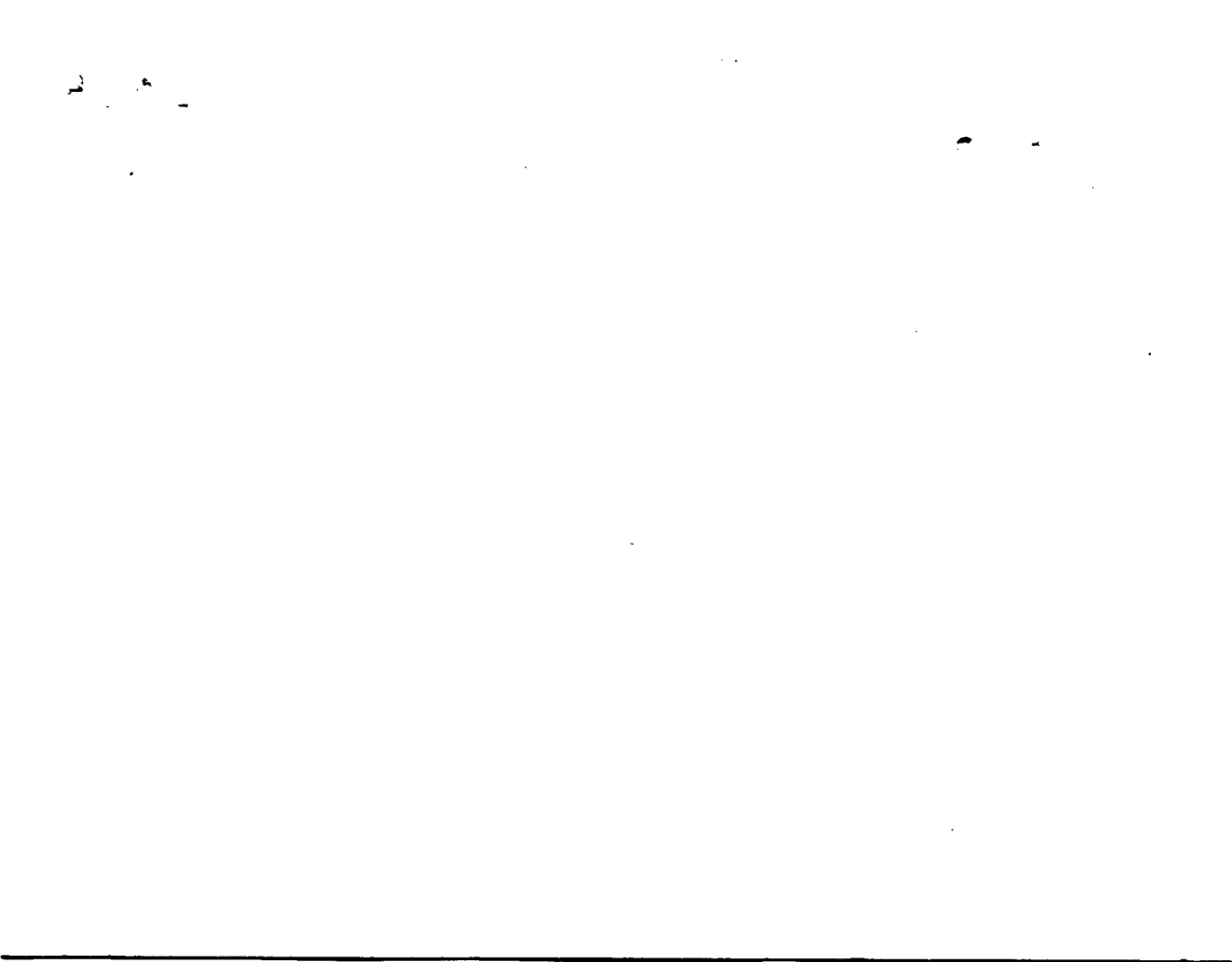
(Physician or midwife)

Address Rebung Idaho

Filed 9/20 19 26 Waymire

Registrar

*Where there was no attending physician or midwife; then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED SEP 14 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 62869

PLACE OF DEATH

CERTIFICATE OF DEATH

County of MadisonRegistration District No. 100City of KAMAH ArcherPrimary Registration District No. 2178Local Registrar's No. 41

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Baby Grover

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Babe5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Babe6 DATE OF BIRTH (month, day and year) August 11, 19287 AGE Years Months Days If LESS than 1 day, _____ hrs. or _____ min.
0 0 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Babe

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Archer, Idaho
(State or country)10 NAME OF FATHER Thomas Marshall Grover11 BIRTHPLACE OF FATHER (city or town)
(State or country) Archer, Idaho12 MAIDEN NAME OF MOTHER Verna Olsen13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lyman Idaho14 Informant O. F. Grover
(Address) Archer, Idaho15 Filed 9/10, 19 28 W. Young
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

8 11 19 28
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from 8-11-28 to 8-11-28, 19 28, that I last saw him alive on 8-11-28, 19 28, and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH* was as follows:

Strangulation
Birth by version
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Large head
(Secondary) 13 1/2 inch circumference
(duration) _____ yrs. _____ mos. _____ ds.18 Where was disease contracted ✓
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? ✓What test confirmed diagnosis? ✓(Signed) Tom J. Rich M. D.
8-13 19 28 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Date of Burial

Archer, Idaho 8/11/28 19

20. Undertaker Address

W. E. Ebersoll Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

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STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

253-123035-866
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Nev. Perce
City of Caldwell, Giffard Idaho

CERTIFICATE OF BIRTH

No. _____ St. _____ Registration District No. 128 State File No. 165203

Hospital _____ Primary Registration District No. _____ Local Registrar's No. _____

FULL NAME OF CHILD _____

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legiti- mate? <u>yes</u>	Date of birth <u>8 23 1928</u>
				(Month) (Day) (Year)

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth none

FULL NAME <u>Thomas Kelly</u>	FATHER
RESIDENCE <u>Giffard Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Farmer</u>	

FULL MAIDEN NAME <u>Opal Marie Howerton</u>	MOTHER
RESIDENCE <u>Giffard Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>20</u> (Years)
BIRTHPLACE <u>Idaho</u>	
OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 3:00 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
_____, 192____

Registrar.

(Signature) George Gaignard M.D.
Physician
(Physician or midwife)
Address Caldwell Idaho
Filed Aug 1928 George Gaignard
Registrar.

Dev

PLACE OF BIRTH

RECEIVED OCT 8 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of TetonCity of DriggsNo. 692-130-041-258 St.Registration District No. 77State File No. S 165260

Hospital

Primary Registration District No. 9176Local Registrar's No. 99

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child

boyTwin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legitimate?

Yes

Date of birth

Sept 301928

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

2

Number of child of this mother now living, including present birth

1

FULL NAME

FATHER

Lester H. Fisher

RESIDENCE

Driggs, Idaho

COLOR

white

AGE AT LAST

BIRTHDAY

25
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

FULL MAIDEN NAME

MOTHER

Elizabeth Seymour

RESIDENCE

Driggs, Ida

COLOR

white

AGE AT LAST

BIRTHDAY

19
(Years)

BIRTHPLACE

Idaho

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 7:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

, 1928

Registrar.

(Signature)

Mrs. Alice Buxton
Nurse

(Physician or midwife)

Address

Driggs, Idaho

Filed

10-4-1928Martha Marker

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

2

RECEIVED OCT 8 - 1928

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 63166
Registered No. 2

1. PLACE OF DEATH

County of Jeton
City of Driggs

Registration District No. 77
Primary Registration District No. 8176
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male white Single
(Write the word.)

6. DATE OF BIRTH

Sept 30 1928
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many _____ hrs.
or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

Infant
"

9. BIRTHPLACE

(State or Country)

Driggs, Idaho

10. NAME OF FATHER

Lester H. Fisher

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Elizabeth Seymour

13. BIRTHPLACE OF MOTHER

(State or Country) *

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lester H. Fisher

(Address)

Driggs, Idaho

15.

Filed 10-14-28 Martha Marker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 30 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 7 P.M. 1928, to 9 P.M. 1928
that I last saw him alive on Sept 30 1928
and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth at
6 months

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Mrs. Alice Buxton Muro M.D.

10-1-1928 (Address) Driggs, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Driggs, Idaho Oct 14 1928

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

442-1101042-349

PLACE OF BIRTH RECEIVED OCT 13 1928 STATE OF IDAHO

County of Adair Falls
City of Hansen - P.F.D
No. _____ St.

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

165336

(If born in hospital or institution
give name.)

Registration District No. 94 State File No. _____

Prim. Registration District No. 2000 Local Registrar's No. _____

FULL NAME OF CHILD

Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <input checked="" type="checkbox"/>	and {	Number in order of birth <input checked="" type="checkbox"/>	Legiti- mate? <u>yes</u>	Date of birth <u>Sept 10</u> 19 <u>28</u> (Month) (Day) (Year)
--------------------------	--	-------	--	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME J H Muse
Residence (Usual place of abode) Hansen
If nonresident, give place and State _____
Color or race White Age at last Birthday 42 (Years)
Birthplace Arkansas (City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Olive Turner
Residence (Usual place of abode) Hansen
If nonresident, give place and State _____
Color or race White Age at last Birthday 35 (Years)
Birthplace Arkansas (City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at _____ M.
on the date above stated.

(Signature) H E Lomb

(Physician ~~and~~ midwife)

Address _____

Filed 1928

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

2

3

4

5

6

7

RECEIVED **6 OCT 10 1928**

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **63182**

PLACE OF DEATH

County of **Twine Falls**

City of **Hauser**

Registration District No. **36**

Primary Registration District No.

Local Registrar's No. **12**

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Truman Dale Murr**

(a) Residence. No. **Hauser** St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. Single, Married, Widowed, or Divorced (write the word) **Single**

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) **Sept. 10 1928**

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **Hauser Ida**
(State or country)

10. NAME OF FATHER **J. B. Murr**

11. BIRTHPLACE OF FATHER (city or town) **Arky**
(State or Country)

12. MAIDEN NAME OF MOTHER **Blue**

13. BIRTHPLACE OF MOTHER (city or town) **Arky**
(State or Country)

14. Informant **J. B. Murr**
(Address) **Hauser Ida**

15. Filed **Sept 11 1928** **M W Davis**
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Sept. 10 1928**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Sept 10th 1928** to **Sept 10th 1928**
that I last saw him alive on **Sept 10th 1928**
and that death occurred, on the date stated above, at **2:20** m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) yrs. mos. ds.

CONTRIBUTORY **Protrusion of cord**
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? **No** Date of

Was there an autopsy? **No**

What test confirmed diagnosis? **Clonus**

(Signed) **H. E. French** M. D.
Sept 10th 1928 (Address) **Twine Falls Ida**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal **Twine Falls** Date of Burial **Sept 10 1928**

20. Undertaker **Prossman** Address **Twine Falls**

MARGIN RESERVED FOR BENDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

964-124643-631
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Booth OCT 13 1928
City of Smiths Ferry

CERTIFICATE OF BIRTH

No. St. Registration District No. 15 State File No. 165344

Hospital Primary Registration District No. Local Registrar's No.

FULL NAME OF CHILD Joe Leroy Romero

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? and { Number in order of birth Legitimate? Yes Date of birth Aug 29 1928
(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 7 Number of child of this mother now living, including present birth 6

FATHER		MOTHER	
FULL NAME	RESIDENCE	FULL MAIDEN NAME	RESIDENCE
<u>Frank Romero</u>	<u>Smiths Ferry, Idaho</u>	<u>Emma Olander</u>	<u>Smiths Ferry Idaho</u>
COLOR <u>Mexican</u>	AGE AT LAST BIRTHDAY <u>66</u> (Years)	COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>39</u> (Years)
BIRTHPLACE <u>Old Mexico</u>		BIRTHPLACE <u>Wisconsin</u>	
OCCUPATION <u>Rancher</u>		OCCUPATION <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE:

I hereby certify that I attended the birth of this child, who was Stillborn at 5:00 M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.

(Signature) Lawson G. Ward

(Physician or midwife)

Address Cascade Idaho

Filed 192

Registrar.

Registrar.

100

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

419-227-001-355
PLACE OF BIRTH

County of Ada NOV 9 1928

City of Burien

No. Shafthorn St.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 165394

Registration District No. 2 State File No. 1004

Prim. Registration District No. 1004 Local Registrar's No. 328

(If born in hospital or institution
give name.)

FULL NAME OF CHILD

Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

7.

Twin
Triplet
or other?

and { Number
in order
of birth

Legiti-
mate?

Yes

Date of
birth

Oct 27

1928

(To be answered only in event of plural births)

(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FATHER
FULL NAME A. F. Darnielle

Residence (Usual place of abode) Gardena

If nonresident, give place and State Ida

Color or race W Age at last Birthday 24

(Years)

Birthplace Mo

(City and State or Country)

Occupation Merchant

MOTHER
FULL MAIDEN NAME Edna Lee

Residence (Usual place of abode) Gardena

If nonresident, give place and State Ida

Color or race W Age at last Birthday 24

(Years)

Birthplace Utah

(City and State or Country)

Occupation HW

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 11:00 M.
on the date above stated.

(Signature) John B. Burt

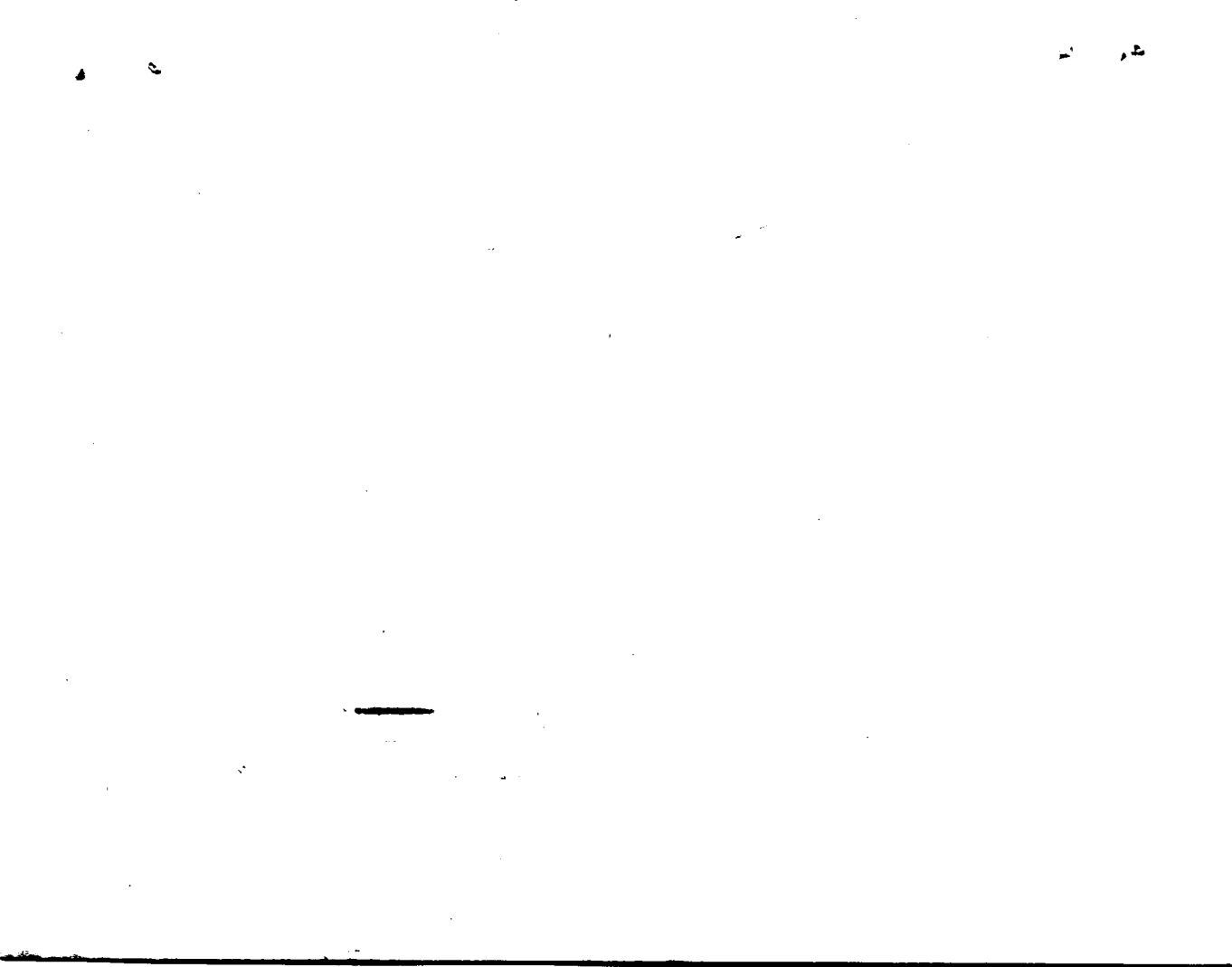
(Physician or midwife)

Address Burien, Ida

Filed 10/30 1928 Paula M. McDonald

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **62899**

RECEIVED SEP 13 1928
PLACE OF DEATH

County of Shoshone
City of Burke, Idaho

Registration District No. 70
Primary Registration District No. 1011
(No. _____)

Local Registrar's No. 98

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn - Premature

(a) Residence. No. _____ St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m
Stillborn
4 mos.
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug 19, 1928

7 AGE Years Months Days
Stillborn
If LESS than day, hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Burke, Idaho
(State or country)

10 NAME OF FATHER Theo. Simonson

11 BIRTHPLACE OF FATHER (city or town) South Dakota
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Green

13 BIRTHPLACE OF MOTHER (city or town) Sweden
(State or country)

14 Informant Theo. Simonson,
(Address) Burke, Idaho

15 Filled Aug 20, 1928 J. L. Lingley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 19, 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from August 19, 1928, to Aug 19, 1928, that I last saw him alive on Aug 19, 1928, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Premature birth - 4 1/2 months

(duration) yrs. mos. ds.

CONTRIBUTORY Undetermined
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) H. L. Lingley, M. D.

Aug 20, 1928 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Burke, Idaho Date of Burial Aug 20, 1928

20. Undertaker None Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

459-122-009-562
PLACE OF BIRTH RECEIVED NOV 7 1928

County of Banner
City of Prest River
No. Prest River St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S** 165523

Registration District No. 85 State File No. 165523
Prim. Registration District No. 2185 Local Registrar's No. 43

FULL NAME OF CHILD Still birth from sons
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin <u>Yes</u> and Number in order of birth <u>1</u> (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of birth <u>Sept 22</u> 19 <u>28</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth two (a) Born alive and now living none
Born alive but now dead none Stillborn

FATHER
FULL NAME William D. Murrell
Residence (Usual place of abode) Prest River, Ida.
If nonresident, give place and State
Color or race white Age at last Birthday 22 (Years)
Birthplace Cody, Wyoming
(City and State or Country)
Occupation Millworker

MOTHER
FULL MAIDEN NAME Pauline Noble
Residence (Usual place of abode) Prest River, Ida.
If nonresident, give place and State
Color or race white Age at last Birthday 16 (Years)
Birthplace Grayfield Wash
(City and State or Country)
Occupation Housewife

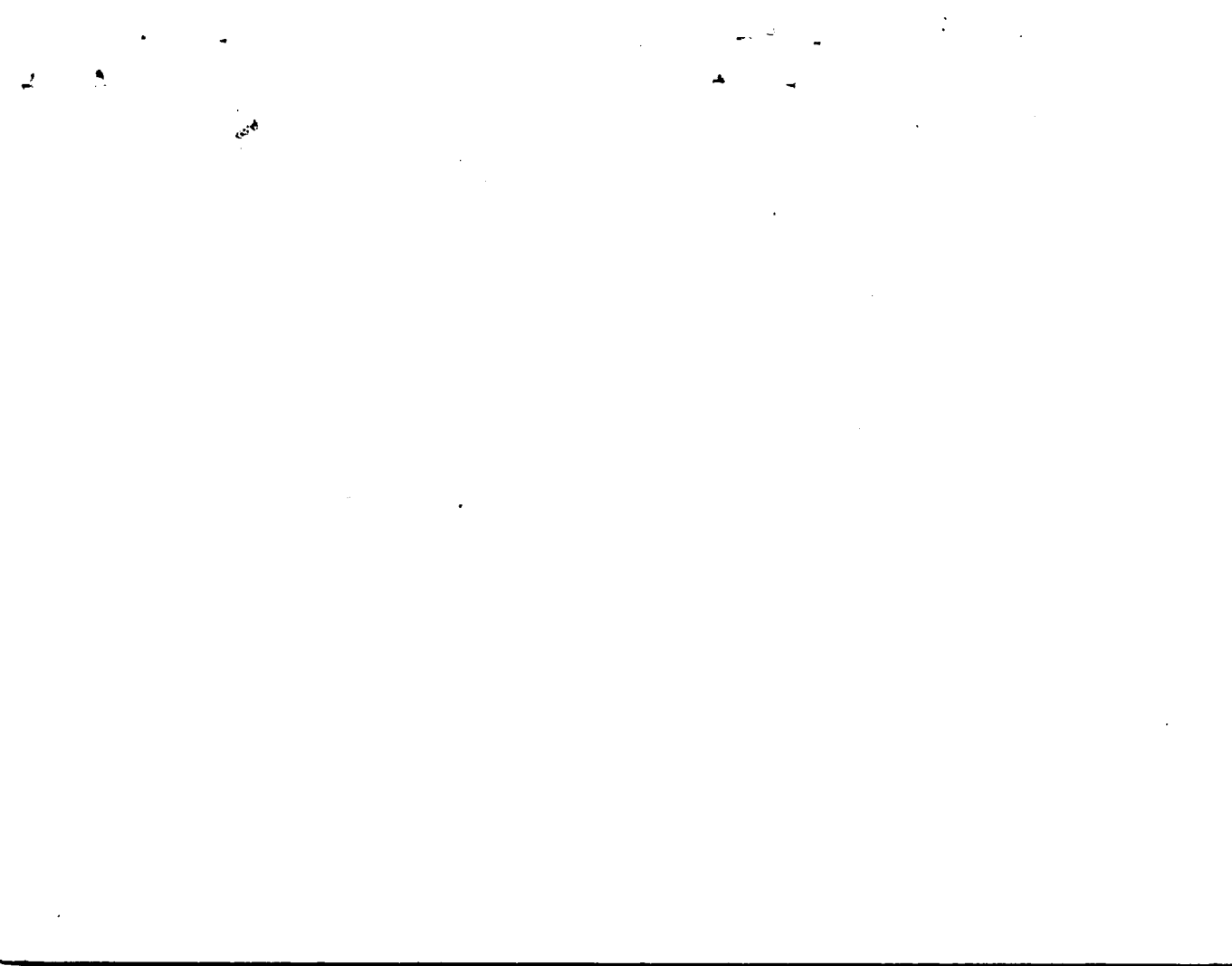
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 10 P. M.
on the date above stated.

(Signature) Dr. L. L. Lauer
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Prest River, Idaho
Filed Oct. 9, 1928 R. E. Wessa
Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 8 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 62986

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Blaine

Registration District No. 85

City of Priest River

Primary Registration District No. 2185

Local Registrar's No. 12

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant of Wm Merrill

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

Sept 22 1928

7 AGE

Years

Months

Days

If LESS than day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Priest River Idaho

10 NAME OF FATHER

Wm. Merrill

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Cody Wyoming

12 MAIDEN NAME OF MOTHER

Caroline Noble

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Garfield Washington

14 Informant

Mrs Wm Merrill

(Address)

Priest River Idaho

15 Filed

Sept 23 1928

H. E. Weiss

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept
(Month)

22
(Day)

1928
(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept 22, 1928 to Sept 22, 1928

that I last saw him alive on Sept 22, 1928

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows

Still birth

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Stillborn

(Signed) J. A. Langer, M. D.

Sept 23, 1928 (Address) Priest River, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Garfield, Wash

Sept 24 1928

20 Undertaker

Address

Mason Mortuary Priest River

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a mid wife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

1238-104-REC-153
OCT 27 1928

PLACE OF BIRTH
County of Bonneville
City of Idaho Falls
No. _____ St. _____
Registration District No. 23 State File No. _____
(If born in hospital or institution give name.)
Prim. Registration District No. 2 Local Registrar's No. 428

CERTIFICATE OF BIRTH **S** 165561

FULL NAME OF CHILD Schuldt Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legiti- mate? <u>ye</u>	Date of birth <u>Sept. 7</u> 19 <u>28</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living _____
Born alive but now dead _____ Stillborn 1

FATHER FULL NAME <u>Schuldt, Ernest H.</u> Residence (Usual place of abode) <u>R 6 Idaho Falls</u> If nonresident, give place and State _____ Color or race <u>white</u> Age at last Birthday <u>20</u> (Years) Birthplace <u>Idaho</u> (City and State or Country) Occupation <u>Mgr. Service station</u>	MOTHER FULL MAIDEN NAME <u>Belnap, Thelma</u> Residence (Usual place of abode) <u>R 6 Idaho Falls</u> If nonresident, give place and State _____ Color or race <u>white</u> Age at last Birthday <u>19</u> (Years) Birthplace <u>Idaho</u> (City and State or Country) Occupation <u>Housewife</u>
--	--

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
Born alive ☒ Stillborn ☐ at 4:15 a. M.
I hereby certify that I attended the birth of this child, who was _____
on the date above stated.
(Signature) W. H. Stillson

(Physician or midwife)
Address Idaho Falls, Idaho
Filed Sept 1 - 1928 Courtney Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

THIS IS A PRELIMINARY RECORD
 IN CASE OF THE CHILD'S DEATH OR MENTAL DEFECT
 WHILE BEING TREATED IN THE HOSPITAL

STATE OF ILLINOIS
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

County of _____
 City of _____
 No. _____
 (All born in hospital or institution)

Registration District No. _____
 Local Registrar's No. _____

FULL NAME OF CHILD _____

(If illegitimate, state the name of mother)

Sex _____
 Date of Birth _____
 Time of Birth _____
 Place of Birth _____
 (To be answered only in case of stillbirth)

What prophylactic was used to prevent (Opthalmia Neonatorum)?

Number of child of this mother, including present birth _____

How many brothers and sisters _____

FATHER
 NAME _____
 MAIDEN NAME _____
 BIRTH _____
 DEATH _____

Residence (Last place of abode) _____

It is recommended, give race and state _____

Color of _____

Age at last birthday _____

Birthplace _____

City and State of Country _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____

on the date above stated _____

(Signature) _____

Address _____

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 63305

PLACE OF DEATH

CERTIFICATE OF DEATH

County of *Bonanza*City of *Idaho Falls*Registration District No. *72*Primary Registration District No. *21V-2*Local Registrar's No. *131*(No. *Health S. Hospital*)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. *Idaho Falls, Ida. St.*

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX *male* 4. COLOR OR RACE *white* 5. Single Married, Widowed, or Divorced (write the word) *Single*5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
no no no

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) *Idaho Falls*
(State or country)10. NAME OF FATHER *Ernest H. Schuldt*11. BIRTHPLACE OF FATHER (city or town) *Iowa*
(State or Country)12. MAIDEN NAME OF MOTHER *Thelma DeNap*13. BIRTHPLACE OF MOTHER (city or town) *Idaho*
(State or Country)14. Informant *Ernest H. Schuldt*
(Address) *Idaho Falls, Ida.*15. Filed *Sept 4*, 19 *28* *Chambers*
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sept 4* 19 *28*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Sept. 4*, 19 *28*, to *Sept. 4*, 19 *28*
that I last saw him alive on *Sept. 4*, 19 *28*
and that death occurred, on the date stated above, at *5 P.* m.
The CAUSE OF DEATH* was as follows:*Stillborn. Dead several days before delivery.*
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)18. Where was disease contracted
if not at place of death?Did an operation precede death? Date of
Was there an autopsy?What test confirmed diagnosis?
(Signed) *Harry P. Hilton* M.D.
Sept. 4, 19 *28* (Address) *Idaho Falls, Ida.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *Idaho Falls* Date of Burial *Sept 4* 19 *28*20. Undertaker *J. F. M. Han* Address *Idaho Falls*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

285-218-2014-653
PLACE OF BIRTH

RECEIVED NOV 7 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Sawyer

City of Naupaka R1

CERTIFICATE OF BIRTH 165588

No. _____ St. _____ Registration District No. _____ State File No. _____

Hospital Home Primary Registration District No. 2006 Local Registrar's No. 38

FULL NAME OF CHILD Infant of Otis Sheldon

(Certificate of no value without full name of child)

Sex of Child 7- Twin Triplet or other? and { Number in order of birth Legitimate? Yes Date of birth 9-18 1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 1

FATHER
FULL NAME Otis Sheldon
RESIDENCE Heise
COLOR white AGE AT LAST BIRTHDAY 24 (Years)
BIRTHPLACE Wis.
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Berula Welker
RESIDENCE Naupaka Ida R1
COLOR white AGE AT LAST BIRTHDAY 23 (Years)
BIRTHPLACE Nebr.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 11 a m on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) V. Bell

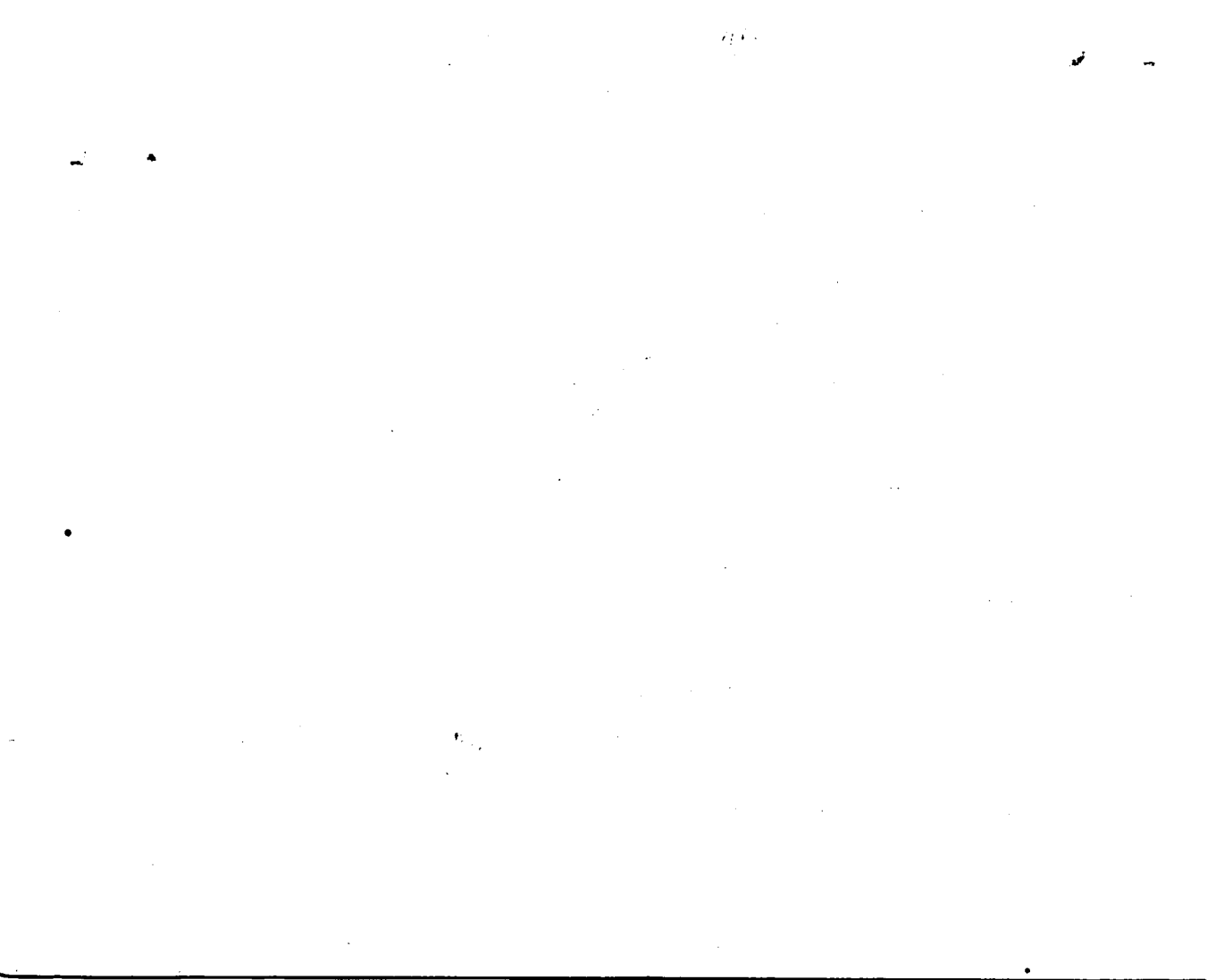
(Physician or midwife)

Address Naupaka Ida R1

Filed 11-2 1928 Berula Welker

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon
City of NampaRegistration District No. 7Primary Registration District No. 100

(No. _____ St.)

State File No. 62999

Local Registrar's No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant of Mrs. Beulah Sheldon
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemale White
(Write the word)

6. DATE OF BIRTH

Sept 18 1928
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
hrs. or
min.?1 Yrs. 1 Mos. 1 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nampa Idaho10. NAME OF
FatherOtis Sheldon11. BIRTHPLACE
OF FATHER

(State or Country)

unknown12. MAIDEN NAME
OF MOTHERBeulah Walker13. BIRTHPLACE
OF MOTHER

(State or Country)

Cambridge
Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. Walker

(Address)

Nampa Idaho

15.

Filed

10-1

1928

Beulah County

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 18 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1928 Sept 18 1928that I last saw him alive onand that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH was as follows:

Still born(Duration) 1 yrs. 1 mos. 1 ds.Contributory
(Secondary)(Duration) 1 yrs. 1 mos. 1 ds.

(Signed)

W. Walker(Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 1 mos. 1 days. In the State 1 yrs. 1 mos. 1 ds.
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bone Idaho9-19 1928

20. UNDERTAKER

ADDRESS

Frank Robinson Nampa

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

862-111-014-127
RECEIVED NOV 13 1928

Form V. S. No. 11-C-25m-7-21-19

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 165606

County of Canyon

City of Wildor

Registration District No. 3

File No. _____

No. _____ St. _____

Hospital _____

Primary Registration District No. 2005 Registered No. 154

FULL NAME OF CHILD

Herold Lyons Gost

sub

Sex of Child

M

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti
mate?

Date of
Birth

Oct 11 1928

(To be answered only in event of plural births)

FULL
NAME

FATHER

Herold E. Gost

FULL
MAIDEN
NAME

MOTHER

Edith J. Papinall

RESIDENCE

Wildor

RESIDENCE

Wildor

COLOR

W

AGE AT LAST
BIRTHDAY

32
(Years)

COLOR

W

AGE AT LAST
BIRTHDAY

32
(Years)

BIRTHPLACE

Ohio

BIRTHPLACE

Ohio

OCCUPATION

Farmer

OCCUPATION

Gov

Number of child of this mother, including present birth 1

Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was stillborn, at 8:30 P. M.
on the date above stated. 2005 Canyon (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

S. Gaffey
Homedale

(Physician or midwife)

Given names added from a supplemental report.

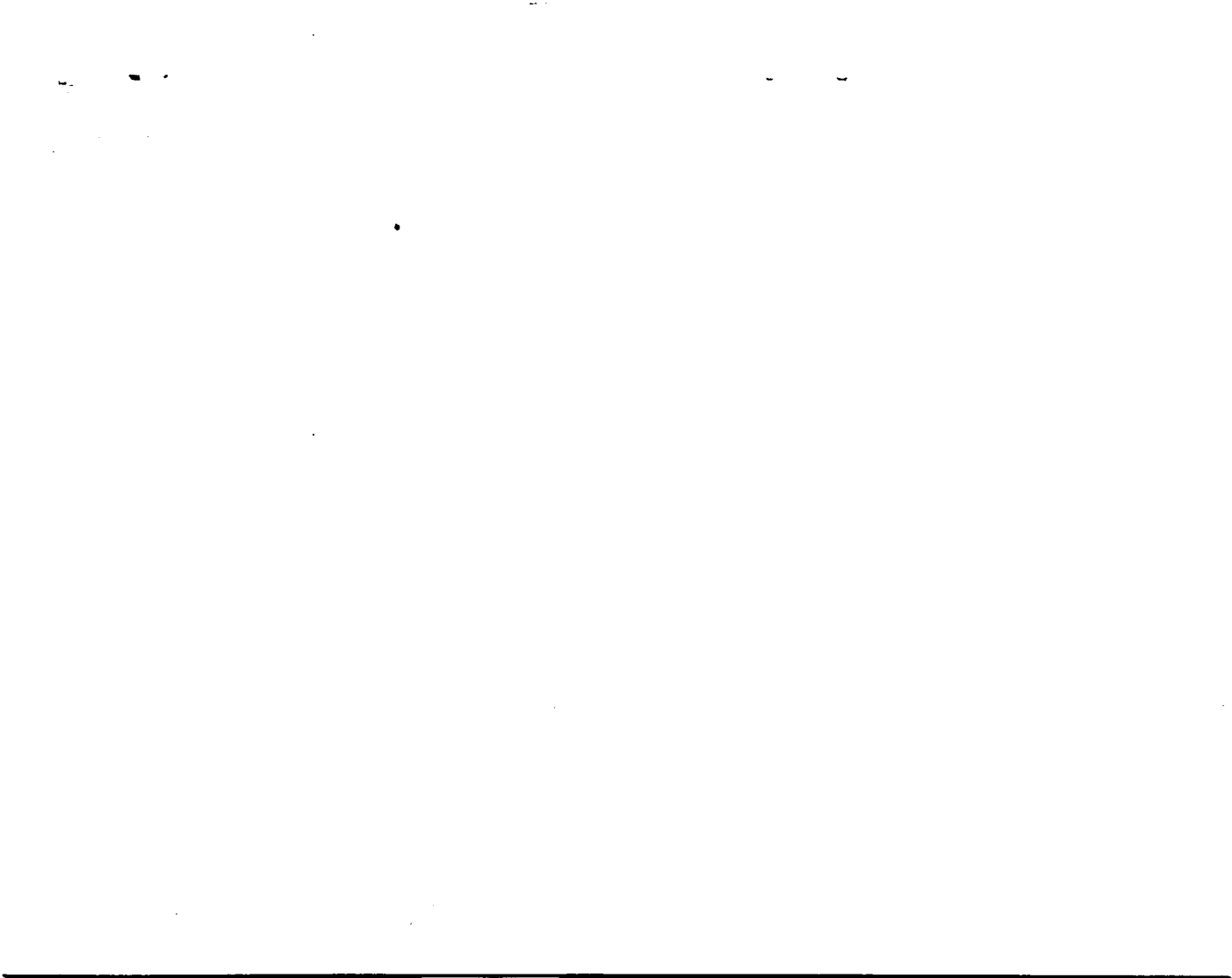
19

Address

Filed

10-13-1928 John C. Meyer
Registrar

Registrar



FORM V. S. RECEIVED NOV 13 1928

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon
City of MiddleRegistration District No. 3
Primary Registration District No. 2005
(No. _____ St.)File No. 63331
Registered No. 95

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harold Louis Gost

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH

Oct 11 1928
(Month) (Day) (Year)

7. AGE

still born
Yrs. Mos. ds.IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Harold E Gost

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Edith C Aspinall

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. C. Gost
(Address) Middle15. Oct 13 - 28 Filed John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 11 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 11 1928, to Oct 11 1928that I last saw him alive on still born 1928and that death occurred on the date stated above, at 8:30 PM

The CAUSE OF DEATH* was as follows:

still born

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) S. Hooper M. D.19 (Address) Hamden

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Fargo Cemetery DATE OF BURIAL Oct 12 192820. UNDERTAKER Father and Uncle ADDRESS Wilder & Co.
G. M. Eidemiller

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

419-028-818-713
PLACE OF BIRTH

County of Clearwater
City of Pine

No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 90 State File No. 165652

Prim. Registration District No. 7168 Local Registrar's No. 97

(If born in hospital or institution give name.)

FULL NAME OF CHILD Miscarage 3 mo

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <input checked="" type="checkbox"/>	Twin <input type="checkbox"/> Triplet <input type="checkbox"/> or other? <input type="checkbox"/> (To be answered only in event of plural births)	and {	Number in order of birth <input type="checkbox"/>	Legitimate? <input checked="" type="checkbox"/>	Date of birth <u>10/28</u> <u>1928</u> (Month) (Day) (Year)
--	--	-------	---	---	--

What prophylactic was used to prevent Ophthalmia Neonatorum? ✓

Number of child of this mother, including present birth ✓ (a) Born alive and now living two

Born alive but now dead none Stillborn one

FATHER
FULL NAME Maynard H. Martin

Residence (Usual place of abode) _____

If nonresident, give place and State _____

Color or race white Age at last Birthday 29 (Years)

Birthplace Clearlake, Cal.
(City and State or Country)

Occupation Lumberjack

MOTHER
FULL MAIDEN NAME Constance E. D. Gatzewicz

Residence (Usual place of abode) _____

If nonresident, give place and State _____

Color or race white Age at last Birthday 27 (Years)

Birthplace Independence, Miss.
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 10/28 M. on the date above stated.

(Signature) [Signature]

(Physician or midwife)

Address 2000 1st St. S. Idaho

Filed Nov 4 1928 Dep. W. G. Shovel

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1017

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

364-1148-020-813
PLACE OF BIRTH

County of Elmore
City of Glenn's Ferry
No. St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
165660

Registration District No. 35 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 2021 Local Registrar's No.

FULL NAME OF CHILD unnamed Stillborn

(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>~</u>	and	Number in order of birth (To be answered only in event of plural births) <u>2</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Aug. 14</u> 19 <u>28</u> (Month) (Day) (Year)
--------------------------	---------------------------------------	-----	--	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead none Stillborn one

FATHER
FULL NAME Fred W. Coulson
Glenn's Ferry

Residence (Usual place of abode) Glenn's Ferry

If nonresident, give place and State

Color or race white Age at last Birthday 24 (Years)

Birthplace Idaho (City and State or Country)

Occupation laborer

MOTHER
FULL MAIDEN NAME Lucille H. Coulson
Glenn's Ferry

Residence (Usual place of abode) Glenn's Ferry

If nonresident, give place and State

Color or race White Age at last Birthday 18 (Years)

Birthplace Idaho (City and State or Country)

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 2 A. M.
on the date above stated.

(Signature) J. W. Davis

Physician
(Physician or midwife)

Address Glenn's Ferry Idaho

Filed Aug. 17 1928 J. W. Davis

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

200

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

153-1031023-455
PLACE OF BIRTH

County of Ben

City of Emmett

No. St.

NOV 3

1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 165716

Registration District No. 6 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD

Still Birth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and } Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>10</u> <u>3</u> <u>1928</u> (Month) (Day) (Year)
--------------------------	--	--------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 7 (a) Born alive and now living 4
Born alive but now dead 0 Stillborn 3

FATHER
FULL NAME Walter Antonson
Residence (Usual place of abode) Emmett
If nonresident, give place and State
Color or race white Age at last Birthday 42 (Years)
Birthplace Utah (City and State or Country)
Occupation miner

MOTHER
FULL MAIDEN NAME Emma Denger
Residence (Usual place of abode) Emmett
If nonresident, give place and State
Color or race white Age at last Birthday 43
Birthplace White Sulphur Springs, Mo (City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 7 48 P. M.
on the date above stated.

(Signature) B. C. Cummings

(Physician or midwife)

Address Emmett

Filed 11/1 1928 J. H. Reynolds

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Don

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE RECEIVED NOV 2 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of

City of

No.

St.

Registration District No.

State File No.

Hospital

Primary Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
Child

Twin
Triplet
or other?

and { Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Date of
birth

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth

Number of child of this mother now living, including present birth

FULL
NAME

FATHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

FULL
MAIDEN
NAME

MOTHER

RESIDENCE

COLOR

AGE AT LAST
BIRTHDAY

(Years)

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 11 P. M.
on the date above stated.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

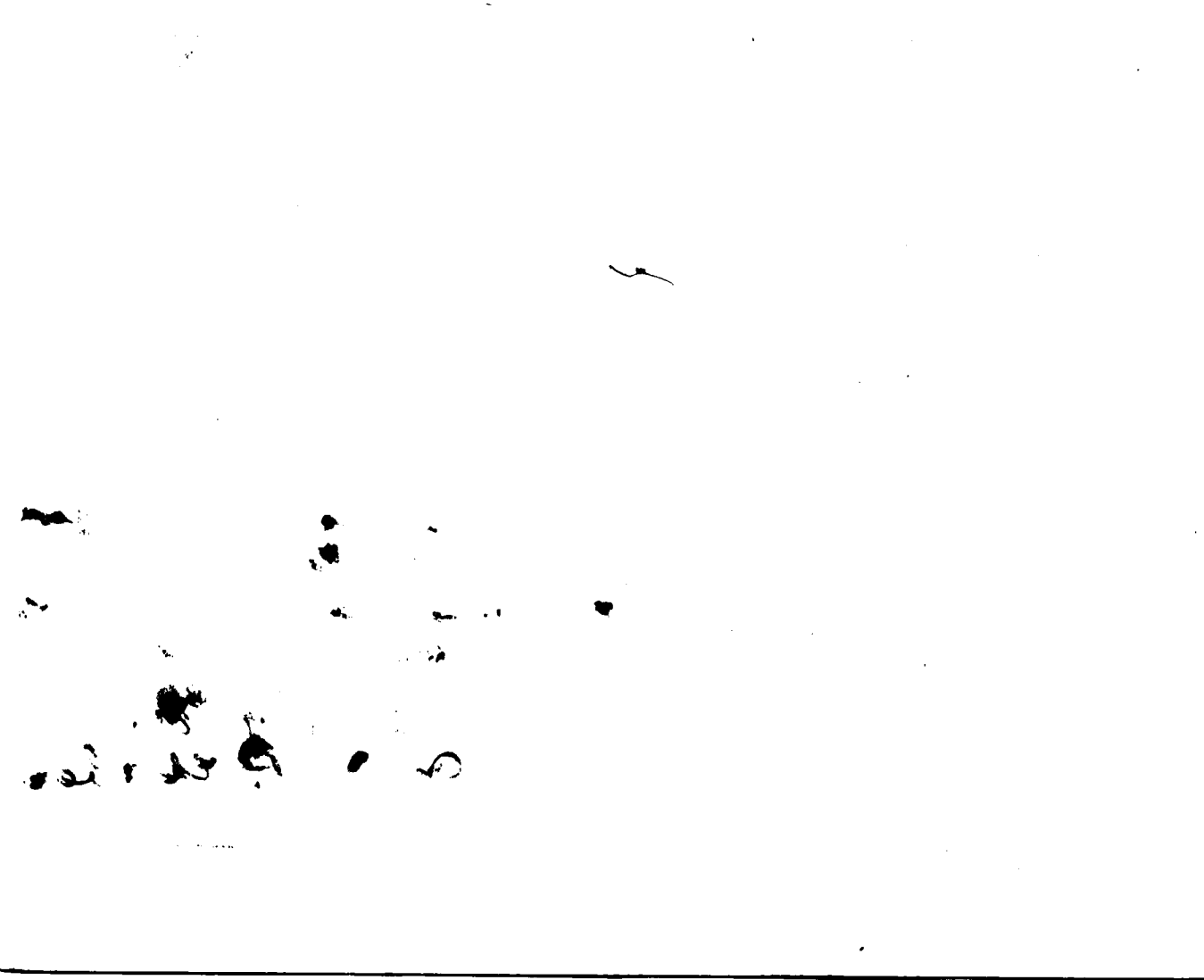
(Physician or ~~midwife~~)

Address

Filed

Registrar.

Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

432-208-228-753
PLACE OF BIRTH

County of Rush
City of _____
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
165743

Registration District No. 30 State File No. _____

Prim. Registration District No. 1051 Local Registrar's No. 167

FULL NAME OF CHILD Immune Mc Bride

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>female</u>	Twin <u>✓</u> Triplet or other?	and { Number in order of birth <u>first</u> }	Legitimacy <u>yes</u>	Date of birth <u>Sept. 8.</u> 19 <u>28</u>
	(To be answered only in event of plural births)			(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None used

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Albert E. Mc Bride</u>	MOTHER FULL MAIDEN NAME <u>Helma A. Peters</u>
---	---

Residence (Usual place of abode) Haysden Lake, Id.

If nonresident, give place and State _____

Color or race white Age at last Birthday 25 (Years)

Birthplace Cleveland, N. Dak. (City and State or Country)

Occupation Rural Mail Carrier

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 3.50 P. M. on the date above stated.

(Signature) Frank E. Hays

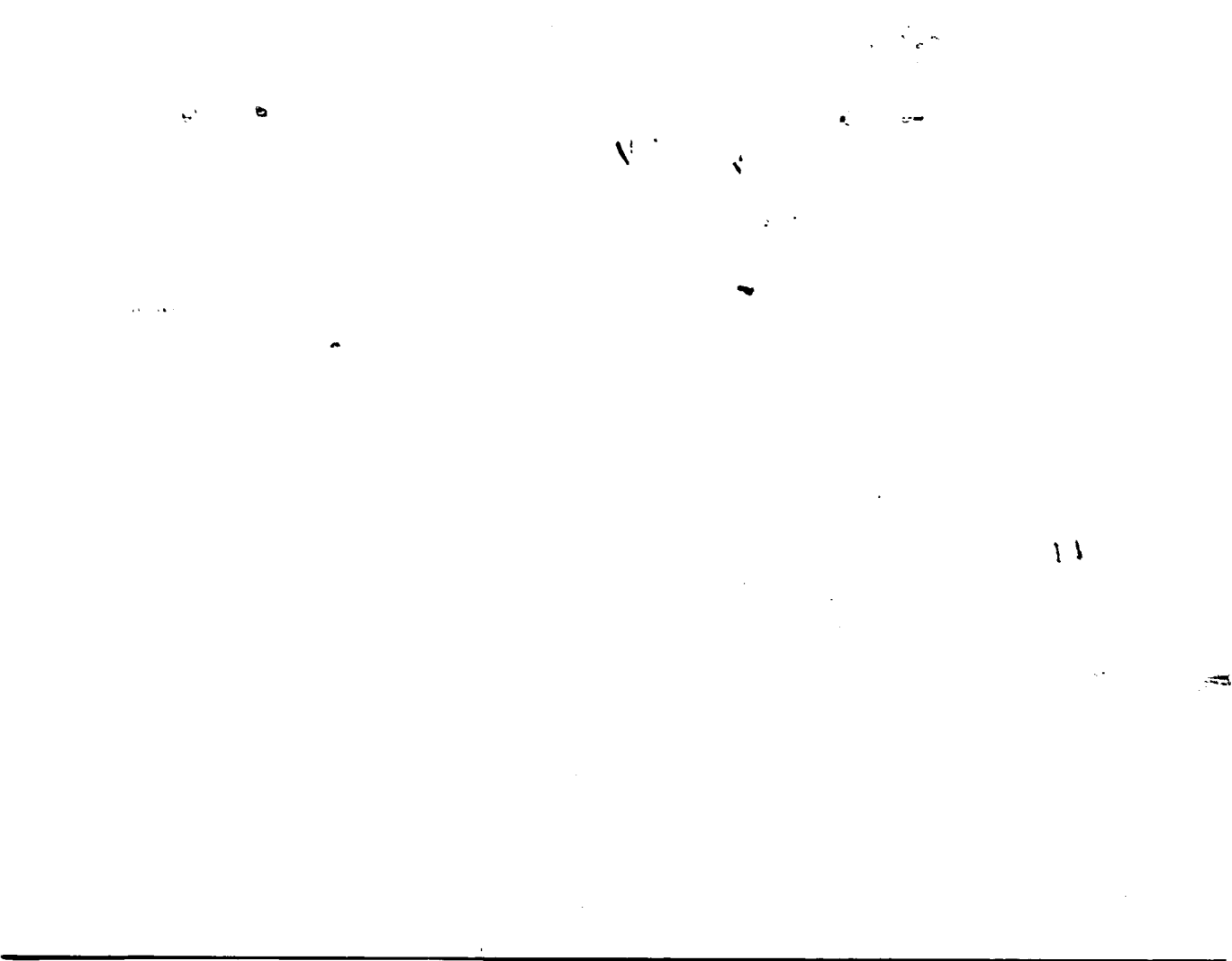
(Physician or midwife)

Address Ratholm, Idaho

Filed 10-4 1928 A. D. Brennan

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 5 1928

PLACE OF DEATH

County of KootenaiCity of RathdrumSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30Primary Registration District No. 1051

DO NOT WRITE IN THIS SPACE

State File No. 63385Local Registrar's No. 137(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME (unnamed) Mc Bride(a) Residence. No. St. Hayden Lake, Ida.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Sep. 8. 19287. AGE Years Months Days If LESS than 1 day, hrs. or min.
stillborn

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Hayden Lake, Ida.
(State or country)10. NAME OF FATHER Albert E. Mc Bride11. BIRTHPLACE OF FATHER (city or town) Cleveland
(State or Country)12. MAIDEN NAME OF MOTHER Kathleen E. Peterson13. BIRTHPLACE OF MOTHER (city or town) Logan, W. Va.
(State or Country)14. Informant Albert E. Mc Bride
(Address) Hayden Lake, Idaho.15. Filed 10/5, 1928 S. S. Brennan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep. 8. 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

stillborn, 1928, to 19that I last saw h alive on 19and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

stillborn - twins. Malposition in utero - chest flattened compressed by head of other twin.

(duration) yrs. mos. ds.

CONTRIBUTORY premature birth -
(Secondary)6 weeks - (duration) yrs. mos. ds.18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank Wenz, M. D.Sep. 9., 1928 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal at Home. Date of Burial 9/9 192820. Undertaker Cassidy Funeral Home Address Rathdrum

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

343-227-
PLACE OF BIRTH
035-862
RECEIVED OCT 17 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

165771

County of Nez Perce
City of Donnelly
No. _____ St. _____
Registration District No. 63 File No. _____
Hospital _____ Primary Registration District No. _____ Registered No. _____
FULL NAME OF CHILD Elaine May Luce

(Certificate of no value without full name of child.)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>aug 27</u> 192 <u>8</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	-----------------------------	---

What bacteriocidal solution was used in eyes? None used Born dead

Number of child of this mother, including present birth. 9 Number of child of this mother now living, including present birth. 7

FATHER		MOTHER	
FULL NAME	<u>Ira H Luce</u>	FULL MAIDEN NAME	<u>Bessie E Hoskins</u>
RESIDENCE	<u>Southwest Idaho</u>	RESIDENCE	<u>Southwest Idaho</u>
COLOR	<u>white</u>	COLOR	<u>white</u>
AGE AT LAST BIRTHDAY	<u>39</u> (Years)	AGE AT LAST BIRTHDAY	<u>34</u> (Years)
BIRTHPLACE	<u>Palmas wash</u>	BIRTHPLACE	<u>Mallett Oregon</u>
OCCUPATION	<u>Minister</u>	OCCUPATION	<u>House wife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born 9 mos 11, 11 M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Russell T. Tamm
Pump
(Physician or midwife)

Give names added from a supplemental report.

Address Southwest Idaho
Filed Aug 28 1928 B. F. Tamm
Registrar.

Registrar.

2.

THE STATE OF NEW YORK
IN SENATE
January 10, 1901.

3. Balance
1000.00
2000.00
3000.00

CERTIFICATE OF DEATH

1. PLACE **RECEIVED OCT 17 1928**
 Registration District No. **63**
 County of **Clearwater** Primary Registration District No. _____
 City of **Southwick** (No. _____ St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louis May Luce

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **63407**
 Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**
 (Write the word.)

6. DATE OF BIRTH **Aug 27 1928**
 (Month) (Day) (Year)

7. AGE **Still Born 9 months** IF LESS than 1 day
 how many _____ hrs.
 Yrs. Mos. da. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry, business or establishment in which employed (or employer).

none

9. BIRTHPLACE

(State or Country)

Clearwater Idaho

10. NAME OF FATHER

Ira H Luce

11. BIRTHPLACE OF FATHER

(State or Country)

Palouse wash

12. MAIDEN NAME OF MOTHER

Berulah E Hawkins

13. BIRTHPLACE OF MOTHER

(State or Country)

Malton Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ira H Luce

(Address)

Southwick Idaho

15.

Filed

Aug 28 1928

B. F. Model
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 27 1928
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to **Aug 27 1928**, that I last saw her **live** on **still born** 19____, and that death occurred on the date stated above, at **11 A.M.**
 The CAUSE OF DEATH* was as follows:
+ Birth - Still Born

(Duration) Yrs. Mos. da.
 Contributory (Secondary)

(Duration) Yrs. Mos. da.

(Signed) **Russell Smith** M. D.

8-27-1928 (Address) **Southwick**

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Hanna Cemetery

DATE OF BURIAL

Aug 28 1928

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth, a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

365-225-029-299

PLACE OF BIRTH

RECEIVED OCT 17 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Latah

City of Crescent

No. _____ St. _____

Registration District No. 63

File No. 165774

Hospital _____

Primary Registration District No. 63

Registered No. _____

FULL NAME OF CHILD

Lottie Looser

(Certificate of no value without full name of child.)

Sex of Child L

Twin
Triplet
or other?

and { Number
in order
of birth }

Legiti-
mate? Yes

Date of birth 8 25 1928
(Month) (Day) (Year)

What bactericidal solution was used in eyes? None used at Birth

Number of child of this mother, including present birth 7

Number of child of this mother now living, including present birth 5

FULL NAME FATHER William H Looser

FULL MAIDEN NAME MOTHER Gertie Kirchknopf

RESIDENCE Crescent Ida

RESIDENCE Crescent Ida

COLOR White AGE AT LAST BIRTHDAY 45 (Years)

COLOR White AGE AT LAST BIRTHDAY 39 (Years)

BIRTHPLACE Germany

BIRTHPLACE S.D

OCCUPATION Harmon

OCCUPATION Ample

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 6 A.M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) Russell Tourist

(Physician or midwife)

Give names added from a supplemental report.

Address Lamonia Ida

Filed Aug 28 1928 B.F. Mott

Registrar.

Registrar.

1941

RECEIVED 00T 17 1928 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 63

County of

Primary Registration District No.

File No.

63408

City of

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lootbie Loeser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female

White

(Write the word.)

6. DATE OF BIRTH

Aug 25th

1928

(Month)

(Day)

(Year)

7. AGE

7 mos in utero

IF LESS than 1 day

how many hrs.

or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William Loeser

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Gertrude Kuchtrup

13. BIRTHPLACE OF MOTHER

(State or Country)

S.D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. H. Loeser

(Address)

Crescent Id.

15.

Filed

Aug 28 1928

19

B. F. M. H.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Still Born)

Aug 25th

1928

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

Aug 25

1928

that I last saw h. on

William

1928

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Still Born likely dead
some time before

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Russell Thrift

M. D.

8-25-1928

(Address) Southwick Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

In the

days

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Southwick Cemetery

8-25-1928

20. UNDERTAKER

None

ADDRESS

Crescent Id.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED NOV 13 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Lemhi

City of Idaho Falls

No. 154-127032-245

Registration District No. 16

State File No.

165801

Hospital

Primary Registration District No. 2016

Local Registrar's No. 41

FULL NAME OF CHILD

Boys

(Certificate of no value without full name of child)

Sex of Child Male

Twin
Triplet
or other? —
(To be answered only in event of plural births)

and { Number
in order
of birth
—
(To be answered only in event of plural births)

Legiti-
mate? yes

Date of birth Oct 27 1928
(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 6

Number of child of this mother now living, including present birth 3

FULL
NAME

FATHER

Adrian Anderson

RESIDENCE

Idaho Falls, Idaho

COLOR

white

AGE AT LAST

BIRTHDAY 34
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Farmer

FULL
MAIDEN
NAME

MOTHER

La Vern Kung

RESIDENCE

Idaho Falls

COLOR

white

AGE AT LAST

BIRTHDAY 33
(Years)

BIRTHPLACE

Idaho

OCCUPATION

Book

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was
on the date above stated.

Born alive {
Stillborn {

at 7:30 P. M.

*When there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

(Physician or midwife)

Address

Filed

1928

Registrar.

Registrar.

40
ON

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

569.130-035 866
PLACE OF BIRTH

NOV 1 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH **S** 165836

County of My Perce

City of Gifford

No. St. Registration District No. 92 State File No.

Hospital Primary Registration District No. 2170 Local Registrar's No. 46

FULL NAME OF CHILD Baby Ewing

(Certificate of no value without full name of child)

Sex of Child <u>m</u>	Twin Triplet or other? <u>\</u>	and {	Number in order of birth <u>\</u>	Legitimate? <u>yes</u>	Date of birth <u>10-30</u> 192 <u>8</u>
					(Month) (Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2

FULL NAME	FATHER
<u>G. Roy Ewing</u>	
RESIDENCE	<u>Gifford</u>
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>35</u> (Years)
BIRTHPLACE	<u>Kansas</u>
OCCUPATION	<u>farmer</u>

FULL MAIDEN NAME	MOTHER
<u>Georgia A Howell</u>	
RESIDENCE	<u>Gifford</u>
COLOR <u>W</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE	<u>Wash</u>
OCCUPATION	<u>hwy</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 4 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. E. Watts

(Physician or midwife)

Address

Filed 10-30 1928 E. E. Watts

Registrar.

Registrar.

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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nej PenceCity of Sifford

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 92Primary Registration District No. 2170

(No. _____ St.)

File No. 63417

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Baby Ewing

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

single

(Write the word.)

6. DATE OF BIRTH

Oct

(Month)

30

(Day)

1928

(Year)

7. AGE

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day

how many _____ hrs.

or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

G. Roy Ewing

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Georgia Howell

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. R. Ewing

(Address)

Sifford Idaho

15.

Filed 10-30 1928E. E. Watts

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct

(Month)

30

(Day)

1928

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

19

to

19that I last saw him alive on 19

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

congenital Hydrocephalus
still born

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. E. Watts

M. D.

10-30-28 (Address) Sifford

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Sifford Idaho

DATE OF BURIAL

10-31-1928

20. UNDERTAKER

ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH Payette RECEIVED NOV 14 1928 STATE OF IDAHO
County of Payette DEPARTMENT OF PUBLIC WELFARE
City of Payette BUREAU OF VITAL STATISTICS
No. 1031 Payette St. CERTIFICATE OF BIRTH S 165864
262-119 038 419 Registration District No. 4 State File No. 38
(If born in hospital or institution
give name.) Pren. Registration District No. 1008 Local Registrar's No. 38

FULL NAME OF CHILD Steelbath
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M.</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Sept. 19 1928</u> (Month) (Day) (Year)
------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Lee Vance Bestwick</u>	MOTHER FULL MAIDEN NAME <u>Bessie Martin</u>
---	---

Residence (Usual place of abode) Payette Ida. Residence (Usual place of abode) Payette Ida.

If nonresident, give place and State. If nonresident, give place and State.

Color or race W Age at last Birthday 37 Color or race W Age at last Birthday 36
(Years) (Years)

Birthplace Medford Oregon Birthplace McMinnville Oregon
(City and State or Country) (City and State or Country)

Occupation Salisman Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at Payette Idaho P. M.
on the date above stated. 30

(Signature) Mona P. Fox

(Physician or midwife)

Address Payette Idaho

Filed Oct 31 1928 J. O. Woodward
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 15

PLACE OF DEATH

County of *Payette*

City of *Payette*

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. *4*
Primary Registration District No. *1008*

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Richard L. Bostwick*

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. Single, Married, Widowed, or Divorced (write the word) *single*

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) *Payette*
(State or country)

10. NAME OF FATHER *Rev. Bostwick*

11. BIRTHPLACE OF FATHER (city or town) *Idaho*
(State or Country)

12. MAIDEN NAME OF MOTHER *Bessie Martin*

13. BIRTHPLACE OF MOTHER (city or town) *Idaho*
(State or Country)

14. Informant *L. V. Bostwick*
(Address) *616 W. 7th, Payette, Ida*

15. Filed *Sept 20, 1928* *J. C. Woodward*
Registrar

DO NOT WRITE IN THIS SPACE

63150

State File No.

Local Registrar's No. *19*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sept. 19, 1928*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept. 19, 1928*, to *Sept. 19, 1928*
that I last saw him alive on *Sept. 19, 1928*

and that death occurred, on the date stated above, at *Idaho* m.

The CAUSE OF DEATH* was as follows:

Stillborn - cause unknown

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? *no*. Date of

Was there an autopsy? *no*.

What test confirmed diagnosis? *none*

(Signed) *Marion R. Taylor* M. D.
Sept 20, 1928 (Address) *Payette, Idaho*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *Payette, Ida.* Date of Burial *Sept 20, 1928*

20. Undertaker *Green C. Anderson* Address *Payette, Ida.*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

MAILED PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED NOV 14 1928

Form V. S. No. 11—20m-7-24-19

PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 165870

433 221 038 - 234

County of Payette

City of Fruitland Ida

No. _____ St. _____

Registration District No. 4

File No. _____

Hospital _____

Primary Registration District No. 1008 Registered No. 64

FULL NAME OF CHILD Pauline McConnell

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>Yes</u>	Date of Birth <u>Oct. 31</u> 19 <u>28</u> (Month) (Day) (Year)
----------------------------	---	-----	--------------------------------	-----------------------------	--

FULL NAME <u>Mrs. H. McConnell</u>	FATHER
RESIDENCE <u>Fruitland Ida</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>25</u> (Years)
BIRTHPLACE <u>Colorado</u>	
OCCUPATION <u>Laborer</u>	

FULL MAIDEN NAME <u>Paula Stuart</u>	MOTHER
RESIDENCE <u>Fruitland Ida</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>24</u> (Years)
BIRTHPLACE <u>Missouri</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

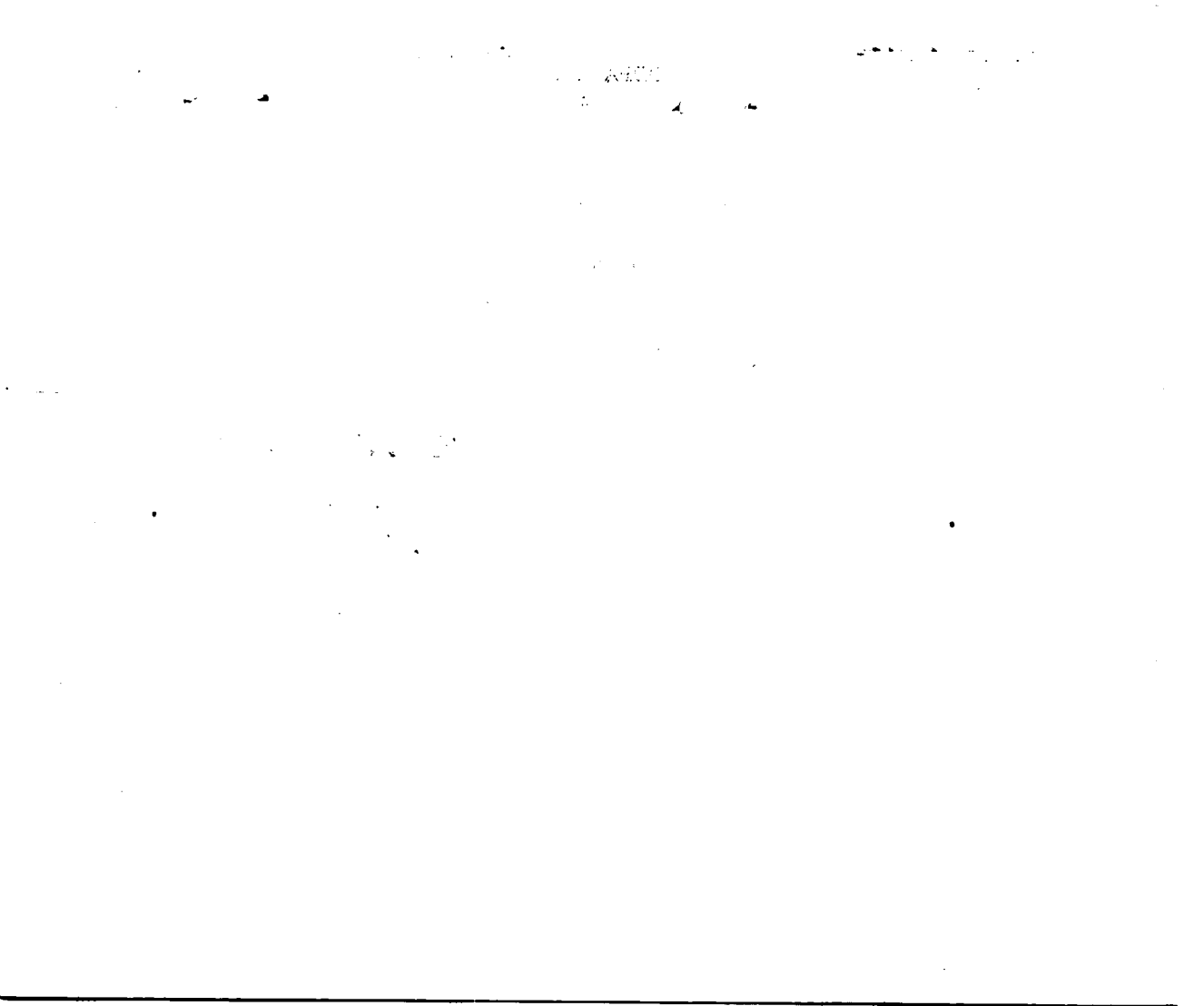
I hereby certify that I attended the birth of this child, who was Stillborn at 8³⁰ P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) O. H. Avery
Physician
(Physician or midwife)

Given names added from a supplemental report.

Address Payette, Ida
Filed Oct 31 1928 J. C. Woodward
Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 14 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 63428

County of Payette
City of Fruitland

CERTIFICATE OF DEATH
Registration District No. 4
Primary Registration District No. 1008

Local Registrar's No. 23

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Pauline McConnell

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Oct 21 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still born

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9. BIRTHPLACE (city or town) Fruitland, Ida
(State or country)

10. NAME OF FATHER Mrs H McConnell

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Colorado

12. MAIDEN NAME OF MOTHER Bessie Stuart

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Missouri

14. Informant Mrs H McConnell
(Address) Fruitland, Ida

15. Filed Oct 24 1928 J. B. Howard
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October 21 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 21 1928, to Oct 21 1928

that I last saw her alive on Oct 21 1928

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born
Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted C
if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) O. H. Army, M. D.
Oct 25 1928 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal _____ Date of Burial _____ 19 _____

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

451-2041038-259
PLACE OF BIRTH

RECEIVED NOV 14 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S
165872

County of Payette

City of Payette

No. _____ St. Registration District No. 4 State File No. _____

Hospital _____ Primary Registration District No. 1008 Local Registrar's No. 66

FULL NAME OF CHILD Unnamed

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Mar 4</u> 192 <u>8</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes? Yes

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME D. N. Dearborne

RESIDENCE 3 miles south of Ontario Oregon

COLOR white AGE AT LAST BIRTHDAY 29 (Years)

BIRTHPLACE Idaho

OCCUPATION Farming

MOTHER
FULL MAIDEN NAME Marguerite Berry

RESIDENCE 3 miles south of Ontario Oregon

COLOR white AGE AT LAST BIRTHDAY 28 (Years)

BIRTHPLACE Idaho

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive Stillborn { at 4³⁰ A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) O. H. Avery

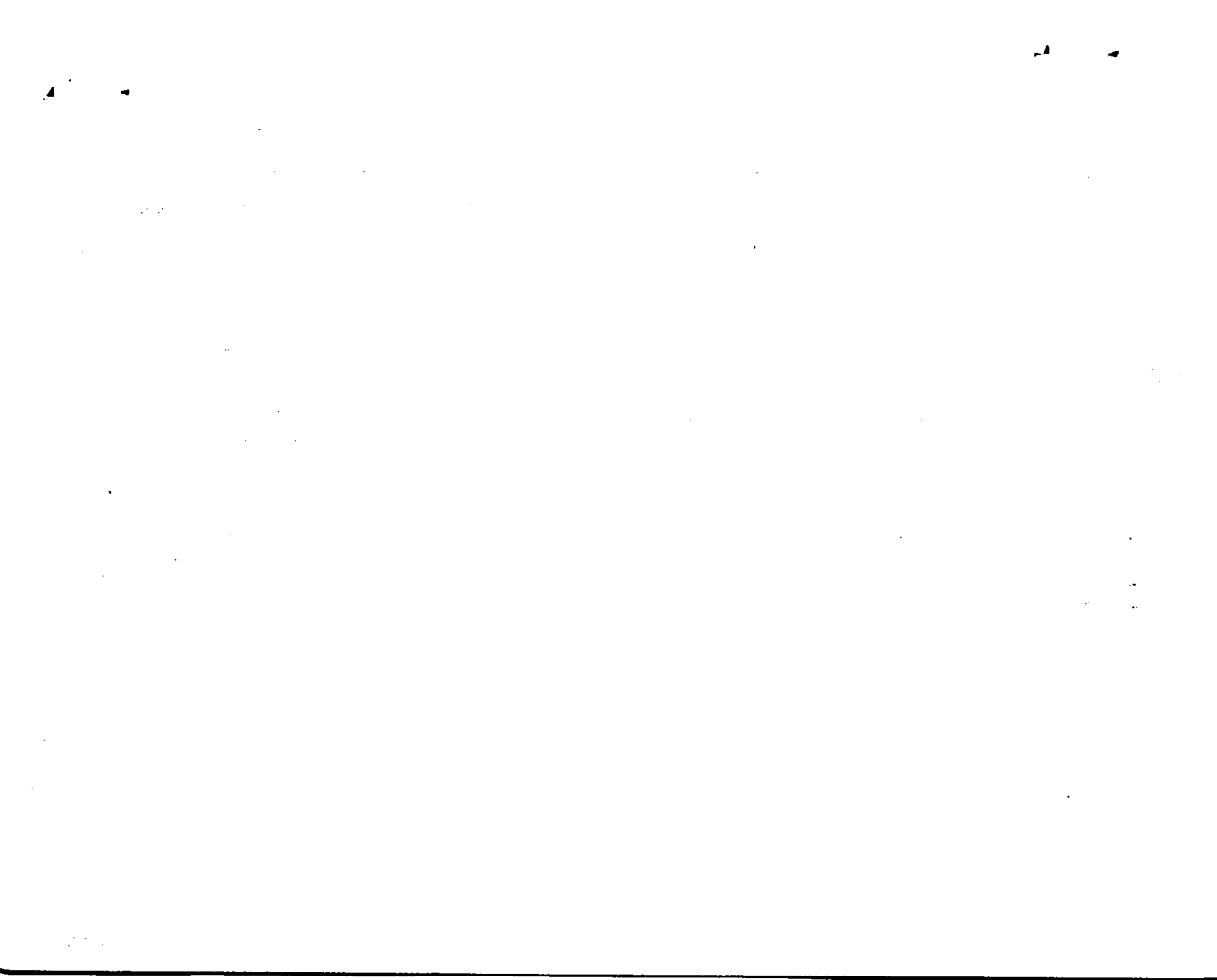
Physician
(Physician or midwife)

Address Payette Ida

Filed Nov 10 1928 J. C. Woodward

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 1 1928
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 63431

County of Payette

City of Payette

Registration District No. 4

Primary Registration District No. 1008

Local Registrar's No. 25

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mumford

(a) Residence. No. St. Ontario Oregon

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 4. 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9. BIRTHPLACE (city or town) Payette Ida
(State or country)

10. NAME OF FATHER O. H. Seaborn

11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Marguerite Berry

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant O. H. Avery
(Address) Payette Ida

15. Filed Nov. 11. 1928 J. O. Woodward
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov 4 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to Nov. 4., 1928

that I last saw him alive on....., 19.....

and that death occurred, on the date stated above, at 4³⁰ a. m.

The CAUSE OF DEATH* was as follows:

Pillborn. Premature labor
induced on account of Uremia
+ threatened Eclampsia. 6 Mg. gestation
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) O. H. Avery, M. D.
Nov. 11, 1928 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Cremated - Payette Date of Burial 19

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc.; Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

966-214040-915
PLACE OF BIRTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Shoshone

RECEIVED NOV 13 1928

City of Arco

CERTIFICATE OF BIRTH

165907

No. 127 St. Registration District No. 2400 State File No. 12

Hospital None Primary Registration District No. 2400 Local Registrar's No. 12

FULL NAME OF CHILD None

(Certificate of no value without full name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>None</u>	and { Number in order of birth <u>1</u> }	Legitimate? <u>Yes</u>	Date of birth <u>Oct 14</u> 192 <u>8</u>
(To be answered only in event of plural births)				(Month) (Day) (Year)

What bactericidal solution was used in eyes? None

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth None

FATHER
FULL NAME John H. Root
RESIDENCE Arco, Idaho
COLOR White AGE AT LAST BIRTHDAY 25 (Years)
BIRTHPLACE Washington
OCCUPATION U. S. Forestry Service

MOTHER
FULL MAIDEN NAME Lillian E. Randolph
RESIDENCE Arco, Idaho
COLOR White AGE AT LAST BIRTHDAY 18 (Years)
BIRTHPLACE Missouri
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

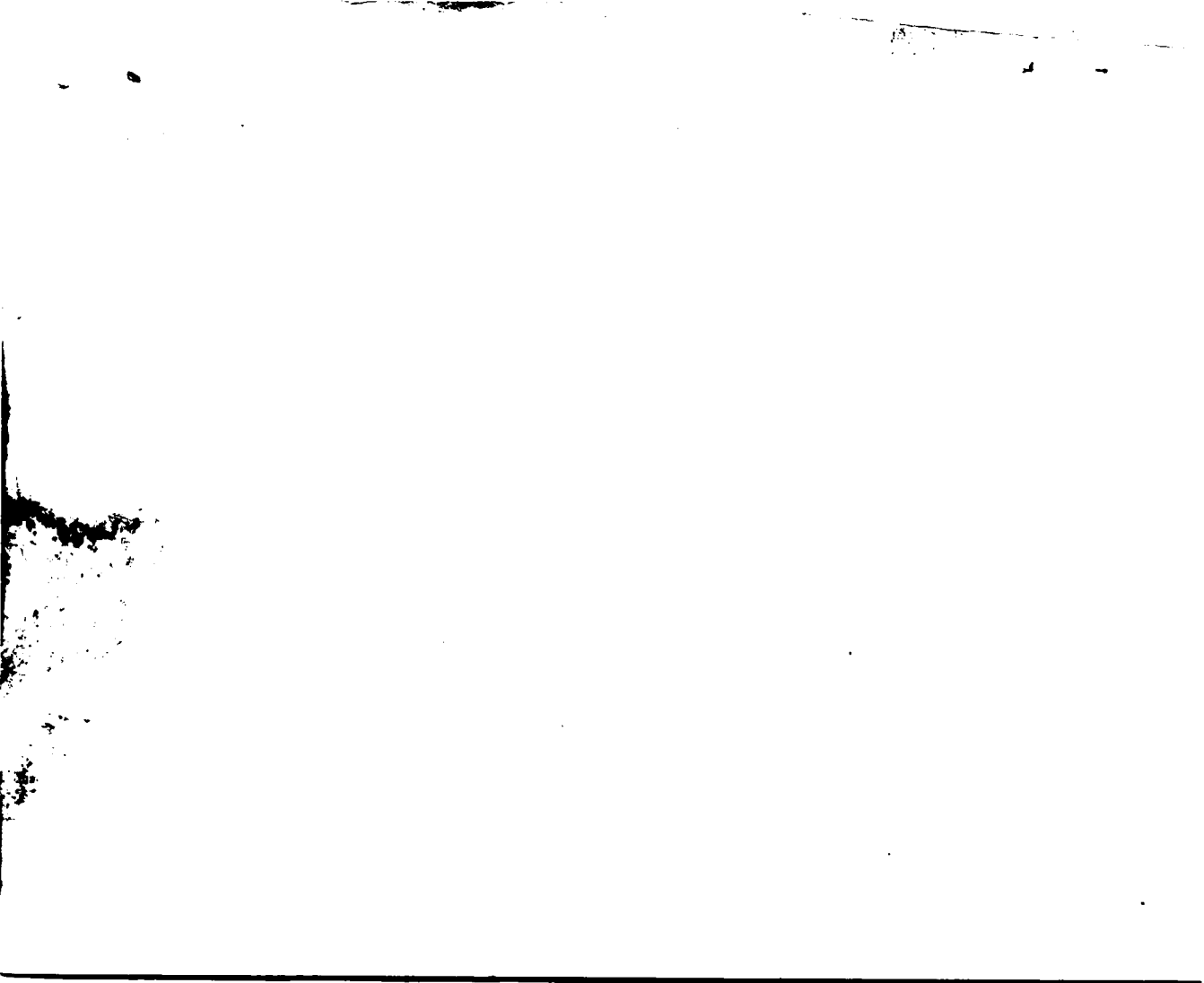
I hereby certify that I attended the birth of this child, who was ☒ Born alive ☐ Stillborn at 4 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. H. Heath
(Physician or midwife)

Address Arco, Idaho
Filed Oct 14 1928 E. H. Heath
Registrar.



RECEIVED NOV 13 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 63453

PLACE OF DEATH

County of Shoshone

City of Arco

Registration District No. 12

Primary Registration District No. 2400

Local Registrar's No. 4

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME No Name

(a) Residence No. St.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years — Months — Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9. BIRTHPLACE (city or town) Arco (State or country) Idaho

10. NAME OF FATHER Jno. H. Root

11. BIRTHPLACE OF FATHER (city or town) Michigan (State or Country)

12. MAIDEN NAME OF MOTHER William Z. Randolph

13. BIRTHPLACE OF MOTHER (city or town) Missouri (State or Country)

14. Informant Jno. H. Root (Address) Arco - Idaho

15. File Oct 14, 19 28 E. W. Heath Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 14 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1928, to Oct 14, 1928

that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at about 4 p.m.

The CAUSE OF DEATH* was as follows: Stillbirth - Premature

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Natural by drainage (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted _____ if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. B. Bury, M. D.

Oct 15, 1928 (Address) Arco Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Arco - Idaho Date of Burial Oct 14 1928

20. Undertaker None Address _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

349 119 240-231
PLACE OF BIRTH RECEIVED NOV 13 1928
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF Shoshone
CITY OF Wallace
No. 7 St. 7
Registration District No. 70 State File No. S 165912
Prim. Registration District No. 111 Local Registrar's No. 100
FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>10-19-1928</u> (Month) (Day) (Year)
-----------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 3 (a) Born alive and now living

Born alive but now dead _____

Stillborn Yes

FULL
NAME

FATHER

FULL
MAIDEN
NAME

MOTHER

Residence (Usual place of abode) Burke Ida

Residence (Usual place of abode) Burke Ida

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race W

Age at last Birthday 28

(Years)

Color or race W

Age at last Birthday 24

(Years)

Birthplace Arkansas

(City and State or Country)

Birthplace Kansas

(City and State or Country)

Occupation Garage Man

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at _____ on the date above stated.

(Signature) Dr. M. W. W. W.

(Physician or midwife)

Address Wallace Idaho

Filed Nov 6 1928

1928

J. H. Quigley

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

NO
D

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

993-119 2042 458
PLACE OF BIRTH
RECEIVED NOV 13 1928
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
S 165981
County of Twin Falls
City of Twin Falls
No. 5 St. Twin Falls
Given Walter
(If born in hospital or institution give name.)
Registration District No. 94 State File No. 165981
P. M. Registration District No. 085 Local Registrar's No. 165981
FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>July 19 1928</u> (Month) (Day) (Year)
--------------------------	---	---	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead _____ Stillborn 1

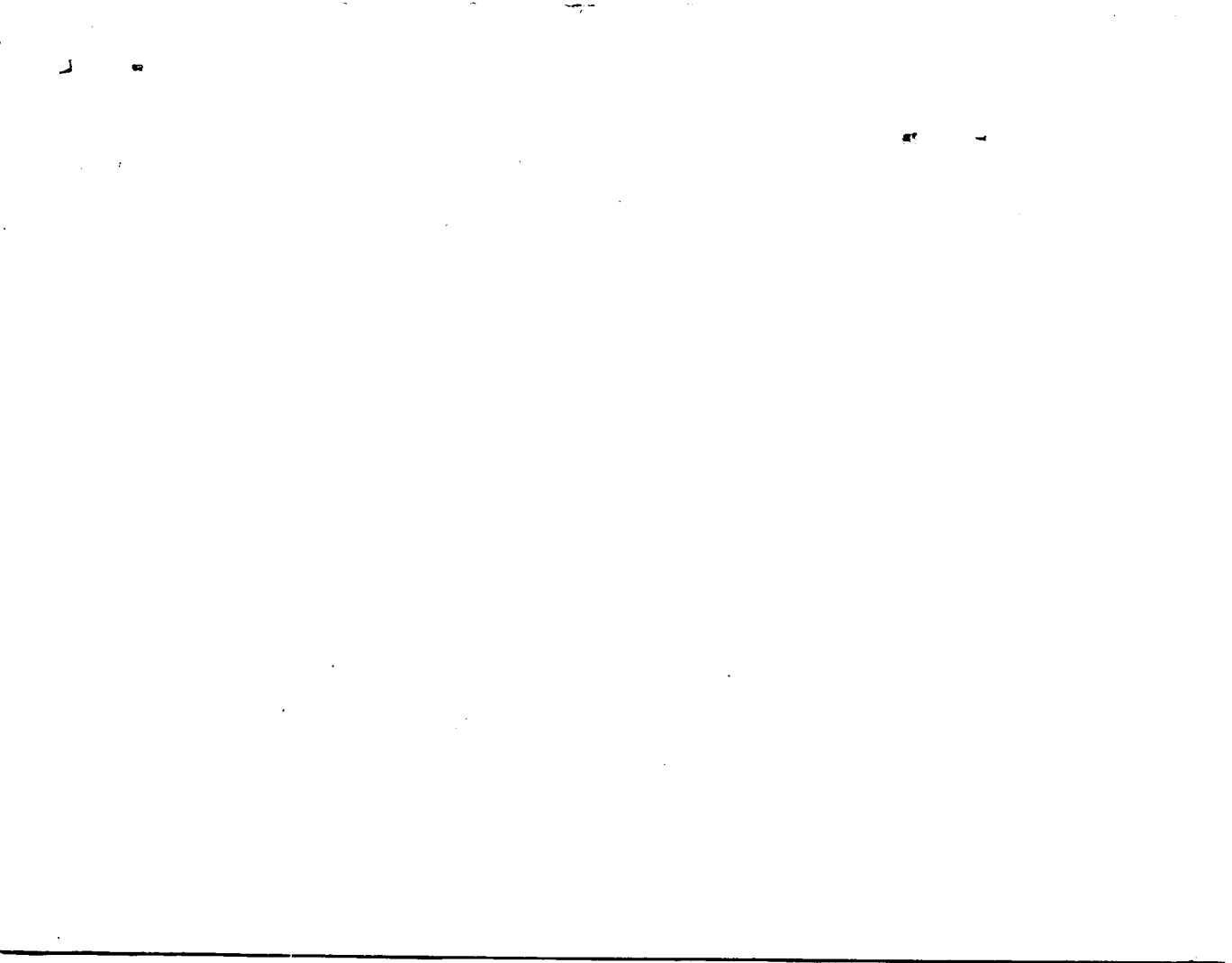
FATHER	MOTHER
FULL NAME <u>Wallace Richardson</u>	FULL MAIDEN NAME <u>Pearl Ruby Reynolds</u>
Residence (Usual place of abode) <u>Twin Falls</u>	Residence (Usual place of abode) <u>Twin Falls</u>
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>white</u> Age at last Birthday <u>28</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>20</u> (Years)
Birthplace <u>Pocatello Idaho</u> (City and State or Country)	Birthplace <u>Hogerson Idaho</u> (City and State or Country)
Occupation <u>laborer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive } at 12 M.
on the date above stated. }
(Signature) Physician

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Twin Falls Idaho
Filed 11 12 1928 Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 13 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 62611

PLACE OF DEATH
County of Jun Falls
City of Jun Falls

Registration District No. 37
Primary Registration District No. 2085

Local Registrar's No. 76

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No.

(Usual place of abode)

Length of residence in city or town where death occurred.

City of Jun Falls State of Idaho
If nonresident give city or town and State)
yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX

Male

4. COLOR OR RACE

white

5. Single, Married, Widowed, or Divorced (write the word)

Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

July 19 / 28

7. AGE

Years

Months

Days

LESS than 1 day,

hrs. or

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)Idaho

10. NAME OF FATHER

Wallace Richardson11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Idaho

12. MAIDEN NAME OF MOTHER

Alice Ballinger13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)California

14. Informant

(Address)

Lezlie Williamson
Jun Falls

15. Filed

8-10 - 1928J. M. Lutz

Registrar

MEDICAL CERTIFICATE OF DEATH

12-30

16. DATE OF DEATH

July191928

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1928

to

July 1928

that I last saw him alive on

and that death occurred, on the date stated above, at 62302 m.

The CAUSE OF DEATH* was as follows:

still born - profusion of umbilical
cord - feet and hands presentation
version - forceps

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of noWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

John J. Lutz M. D.
July 19 1928 (Address) Jun Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Jun Falls Cemetery July 21 1928

20. Undertaker

Address

J. E. Drake Jun Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately* and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED OCT 16 1928

STATE OF IDAHO

County of D. Washington

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

City of

No. 275-219 044 759 St.

CERTIFICATE OF BIRTH

S 166005

Mrs. Selma
(If born in hospital or institution
give name.)

Registration District No. 86 State File No. 166005

Prim. Registration District No. 1010 Local Registrar's No. 19

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>7-19-</u> <u>1929</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Lester Stollis Spencer

Residence (Usual place of abode)

If nonresident, give place and State Council Ida

Color or race white Age at last Birthday 38
(Years)

Birthplace Idaho Wisc.
(City and State or Country)

Occupation Lawyer

MOTHER
FULL MAIDEN NAME Lillian Perkins

Residence (Usual place of abode)

If nonresident, give place and State Council Ida

Color or race white Age at last Birthday 21
(Years)

Birthplace Idaho
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 7-19-31 12:30 P. M.
on the date above stated.

(Signature) Conrad O. Finney

(Physician or midwife)

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

Address

Filed 5/1 1925 M. R. Hamelt

Registrar.

54-1-72

54-1-72

54-1-72

RECEIVED AUG 11 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 62620

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Washington Registration District No. 76City of Wenatchee Primary Registration District No. 1010Local Registrar's No. 3

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Genevieve Spencer(a) Residence, No. Council Id St.(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE Wht 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day and year) July 19-287 AGE Years Months Days 9 If LESS than 1 day, hrs. or min. 0

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Idaho
(State or country)10 NAME OF FATHER Lester H. Spencer11 BIRTHPLACE OF FATHER (city or town) Sola, Wis
(State or country)12 MAIDEN NAME OF MOTHER Helena Perkins13 BIRTHPLACE OF MOTHER (city or town) Oakblong
(State or country)14 Informant Lester Spencer
(Address) Idaho15 Filled July 20, 19 28 H. H. Hamilton
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
July (Month) 19 (Day) 28 (Year)I HEREBY CERTIFY, that I attended deceased from July 19, 19 28, to July 14, 19 28,
that I last saw him alive on July 14, 19 28,
and that death occurred, on the date stated above, at 19 m.

The CAUSE OF DEATH* was as follows:

Still Birth
Congenital Abortion
(duration) yrs. mos. 0 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank F. Fanning, M. D.
July 14, 19 28 (Address) Wenatchee, Ida.*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.19 Place of Burial, Cremation, or Removal Helge's Cemetery Date of Burial 7-20 19 2820 Undertaker L. B. Northrup Address Wenatchee, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED NOV 20 1928 STATE OF IDAHO
County of Bernard DEPARTMENT OF PUBLIC WELFARE
City of Boise BUREAU OF VITAL STATISTICS
No. St. CERTIFICATE OF BIRTH **S**
365 120 003 967 Registration District No. 28 State File No. 166089
(If born in hospital or institution give name.) Prim. Registration District No. 216 Local Registrar's No. 8906

FULL NAME OF CHILD Stillborn
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legit- mate <u>Yes</u>	Date of birth <u>October 20 1928</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? Yes

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead 1 Stillborn 1

FULL NAME <u>Ralph Langton</u> FATHER	FULL MAIDEN NAME <u>Ma May Peterson</u> MOTHER
--	---

Residence (Usual place of abode) same

If nonresident, give place and State

Color or race White Age at last Birthday 26 (Years)

Birthplace Myakka, Ont. (City and State or Country)

Occupation Teacher

If nonresident, give place and State

Color or race White Age at last Birthday 19 (Years)

Birthplace Regent (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5 15 A. M. on the date above stated.

(Signature) D C Ray

(Physician or midwife)

Address Boise, Idaho

Filed 11/1 1928 W. Young Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

APR 6 1954

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 63555

RECEIVED NOV 20 1928
County of BANNOCK
City of POCATELLO

Registration District No. 28
Primary Registration District No. 2161

Local Registrar's No. 5402

(No. RESIDENCE NORTH OF POCATELLO CITY)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME INFANT LANGTON

(a) Residence. No. NORTH OF POCATELLO, St. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>MALE</u>	4. COLOR OR RACE <u>WHITE</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>SINGLE</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) <u>OCT. 20 1928</u>		
7. AGE Years <u>0</u>	Months <u>0</u>	Days <u>0</u> If LESS than 1 day, <u>STILL BORN</u> hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>NONE</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (city or town) POCATELLO, IDAHO
(State or country)

10. NAME OF FATHER <u>RALPH LANGTON</u>
11. BIRTHPLACE OF FATHER (city or town) (State or Country) <u>CANADA</u>
12. MAIDEN NAME OF MOTHER <u>LDA MAY ROBINSON</u>
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <u>CANADA</u>

14. Informant RALPH LANGTON
(Address) POCATELLO, IDAHO

15. Filed 10/24, 1928
Registrar [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
OCT. 20, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to OCT 20, 1928

that I last saw him _____ alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows: hydrocephalus

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? DC Ray, M. D.
(Signed) 10 20, 1928 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal MOUNTAIN VIEW CEMETERY Date of Burial OCT. 21, 1928

20. Undertaker ARTHUR W. HALL Address POCATELLO

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH

RECEIVED DEC 7 1928

STATE OF IDAHO
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Form V. S. No. 11—25m-4-18-18

County of BearCity of BearNo. 695-106.005-291 St.Registration District No. 31File No. 66125

Primary Registration District No. _____

Registered No. _____

Hospital _____

Full Name of Child Unnamed Fureley

SEX OF CHILD <u>M</u>	Twin Triplet or other? _____	{and} Number in order of birth _____	Legiti- mate? <u>yes</u>	DATE OF BIRTH <u>Nov 6 1928</u> (Month) (Day) (Year)
-----------------------	------------------------------------	--	-----------------------------	--

FULL NAME <u>May Fureley</u>	FATHER
RESIDENCE <u>Bear</u>	
COLOR <u>Indian</u>	AGE AT LAST BIRTHDAY <u>23</u> (Years)
BIRTHPLACE <u>Monkman</u>	
OCCUPATION <u>Laborman</u>	

FULL MAIDEN NAME <u>Mary Sigoh</u>	MOTHER
RESIDENCE <u>Idaho</u>	
COLOR <u>Indian</u>	AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Conradale Bear</u>	
OCCUPATION <u>Housewife</u>	

Number of child of this mother, including present birth. 6 Number of children of this mother now living, including present birth. 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 6 P. M.
on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. A. Nelson

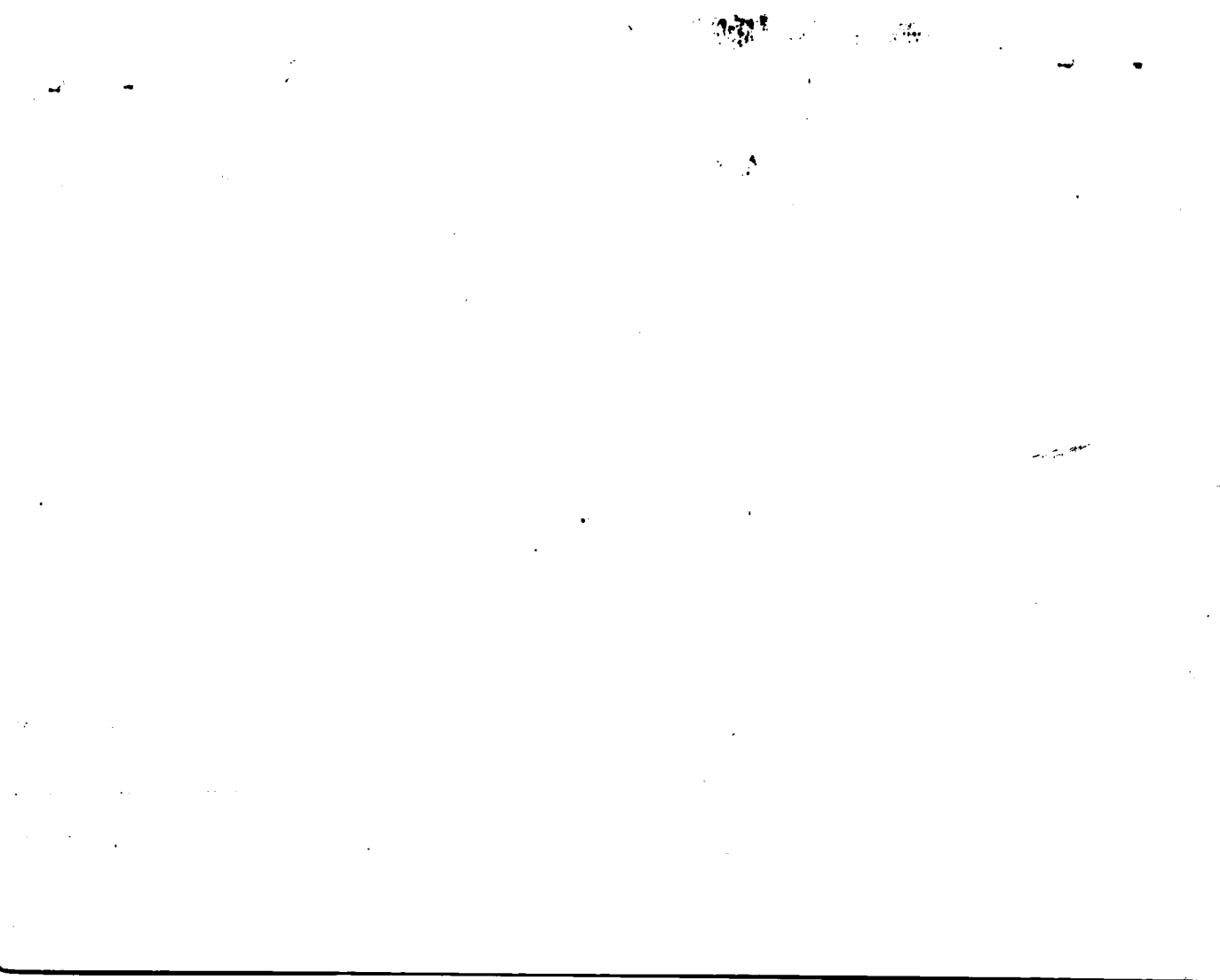
(Physician or midwife)

Given names added from a supplemental report.

Address Des MoinesFiled Nov. 12 1928

Registrar

Registrar John R. Post



RECEIVED DEPT. 1225
STANDARD CERTIFICATE OF DEATHDEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH *Reverah* State *Idaho*
 County _____ State _____
 Township _____ or Village _____
 City *Dermot* No. _____ St., _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME *Unnamed Finley*

(a) Residence. No. _____

(Usual place of abode)

St., _____ Ward. _____

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *Indian*5 SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word) *Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of *Infant*6 DATE OF BIRTH (month, day, and year) *Nov 6 - 28*

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.*Stillborn*

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work _____(b) General nature of industry,
business, or establishment in
which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) *Reverah Co.*(State or country) *Idaho, Conrad Allen Reverah*10 NAME OF FATHER *Max Finley*11 BIRTHPLACE OF FATHER (city or town) *Idaho*(State or country) *Idaho, Conrad Allen Reverah*12 MAIDEN NAME OF MOTHER *Mary Sygah*13 BIRTHPLACE OF MOTHER (city or town) *Idaho*(State or country) *Idaho, Conrad Allen Reverah*

14

Informant *N*

(Address) _____

15

Filed *Dec. 10, 1928**John Post*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Stillborn*17 I HEREBY CERTIFY, That I attended deceased from
Nov 6, 1928, to Nov 6, 1928

that I last saw him _____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

*Premature birth
Monstrous*

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY

(SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *J. A. Nelson* M. D.Address *Dermot, Idaho** State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

St. Luke's Id

19

20 UNDERTAKER

ADDRESS

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite), *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Infantion," "Marasmus," "Old age," "Shock," "Tremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

11—3184

ADDITIONAL SPACE FOR FURTHER STATEMENTS

BY PHYSICIAN.

819-102-005 RECEIVED NOV 15

PLACE OF BIRTH

Form V. S. No. 11-25m-6-16-18

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of LincolnCity of Plummer

No. _____ St. _____

Registration District No. 46File No. 66135Primary Registration District No. 2123Registered No. 9

Hospital _____

Full Name of Child Unnamed Gorber

SEX OF CHILD <u>m</u>	Twin Triplet or other? (To be answered only in event of plural births)	—	and	Number in order of birth (To be answered only in event of plural births)	—	Legiti- mate? <u>yes</u>	DATE OF BIRTH <u>Apr 2-28</u> (Month) (Day) (Year)
FATHER				MOTHER			
FULL NAME <u>Henry Gorber</u>				FULL MAIDEN NAME <u>Ella Agte</u>			
RESIDENCE <u>Plummer Ida</u>				RESIDENCE <u>Idaho</u>			
COLOR <u>W.</u>		AGE AT LAST BIRTHDAY <u>25</u> (Years)		COLOR <u>W</u>		AGE AT LAST BIRTHDAY <u>20</u> (Years)	
BIRTHPLACE <u>Wash.</u>				BIRTHPLACE <u>Wash</u>			
OCCUPATION <u>Woodman</u>				OCCUPATION <u>Wife</u>			

Number of child of this mother, including present birth 1 Number of children of this mother now living, including present birth None

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn, at 12:05 M on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) J. A. Nelson

(Physician or midwife)

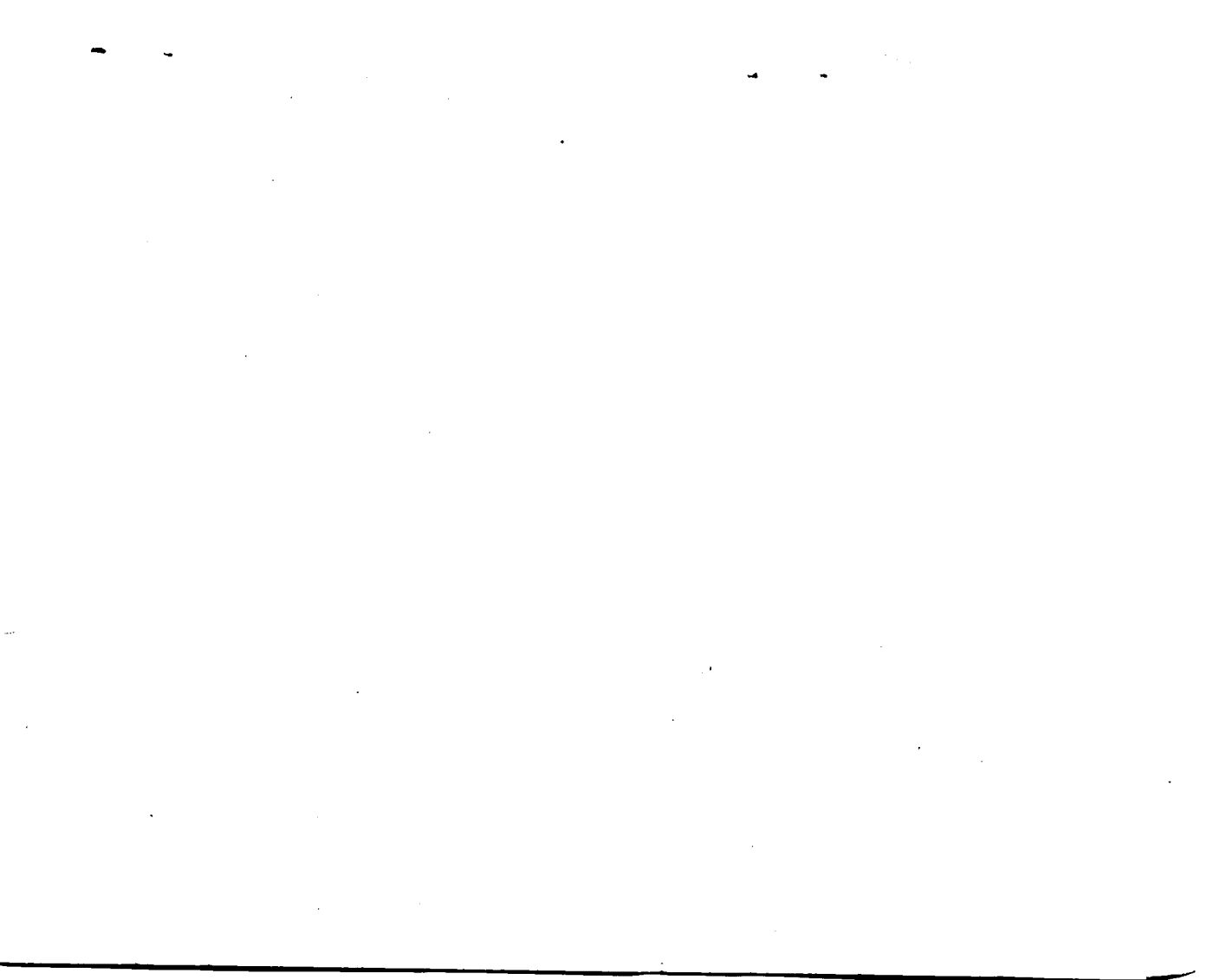
Given names added from a supplemental report.

19. _____

Address IdahoFiled Sept 1419. 28

Registrar

Registrar



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

RECEIVED NOV 1 STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Beaver State Idaho Registered No. 63576 44
Township _____ or Village Plummer _____ or
City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Unnamed Garber Reg. District 46
Residing Reg. Dist. 2123
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept 27-28

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, --- hrs. or --- min. Still born

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ none

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____
(State or country) Plummer Id

10 NAME OF FATHER Henry Garber

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Wash

12 MAIDEN NAME OF MOTHER Ella Agte

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Wash

14 Informant Henry Garber
(Address) Plummer Id

15 Filed Sept 2, 1928 W. J. Jager
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1928

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h. --- alive on _____, 19____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows

Breach presentation,

(Strangulation)
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. A. Nelson M. D.
9/2/28 (Address) Beaumont

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Plummer, Id DATE OF BURIAL Sept 2 1928

20 UNDERTAKER W. J. Jager ADDRESS Plummer

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.*; *Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Intoxication," "Marasmus," "Old age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

11—3184

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

213-21-010-319
PLACE OF BIRTH

County of Bingham
City of _____
No. _____ St. _____

RECEIVED DEC 8 1928 DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 166217

Registration District No. 73 State File No. _____

(If born in hospital or institution give name.)

Prim. Registration District No. 1-2 Local Registrar's No. 567

FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	Number in order of birth _____	Legitimate? <u>yes</u>	Date of birth <u>Sept 21</u> 19 <u>28</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth _____ (a) Born alive and now living _____

Born alive but now dead _____ Stillborn 2

FATHER
FULL NAME Dewey Jewel Ballard
Residence (Usual place of abode) Pinckney Ida
If nonresident, give place and State _____
Color or race White Age at last Birthday 25 (Years)
Birthplace Cole Missouri
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Nellie Fern Carlston
Residence (Usual place of abode) Pinckney Ida
If nonresident, give place and State _____
Color or race White Age at last Birthday 21 (Years)
Birthplace Bingham Canyon Utah
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Stillborn } at 7³⁰ P. M. on the date above stated.

(Signature) H. D. Spencer M.D.

(Physician or midwife)

Address Seabe Lagoon

Filed Mr. D. 19 28 U.S. Bureau

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

2 2

2 2

2 2

2 2

Information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 27 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 63298

County of _____

Registration District No. 73

City of _____

Primary Registration District No. 2140

Local Registrar's No. 34

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Ballard

(a) Residence. No. Purple 24 St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 21, 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Born dead

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls
(State or country)

10. NAME OF FATHER Nevoy Ballard

11. BIRTHPLACE OF FATHER (city or town) Id.
(State or Country)

12. MAIDEN NAME OF MOTHER Nellie Carlston

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Nevoy Ballard

(Address) Purple 24

15. Filed Sept 22, 1928 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 22 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21, 1928, to 19,
that I last saw him alive on 19,
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Stillborn

CONTRIBUTORY
(Secondary)

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. A. D. Spencer M. D.

by Jessie Maranda P.M.
Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Blackfoot Ida Sept 23, 1928

20. Undertaker Address

Chaffey Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Canyon

City of Parma

No. 445-227-014-236 St.

(If born in hospital or institution
give name.)

Registration District No. 3 State File No. 66334

Prim. Registration District No. 2007 Local Registrar's No. 77

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twins Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>Nov. 27</u> 19 <u>28</u> (Month) (Day) (Year)
----------------------------	--	-------	---	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? Stillborn

Number of child of this mother, including present birth 5 (a) Born alive and now living none

Born alive but now dead 3 Stillborn 2

FATHER FULL NAME <u>Willard G. Denny</u>	MOTHER FULL MAIDEN NAME <u>Verda Stout</u>
---	---

Residence (Usual place of abode) Parma Ida.

If nonresident give place and State —

Color or race White Age at last Birthday 29 (Years)

Birthplace Idaho (City and State or Country)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 13:30 A.M. on the date above stated.

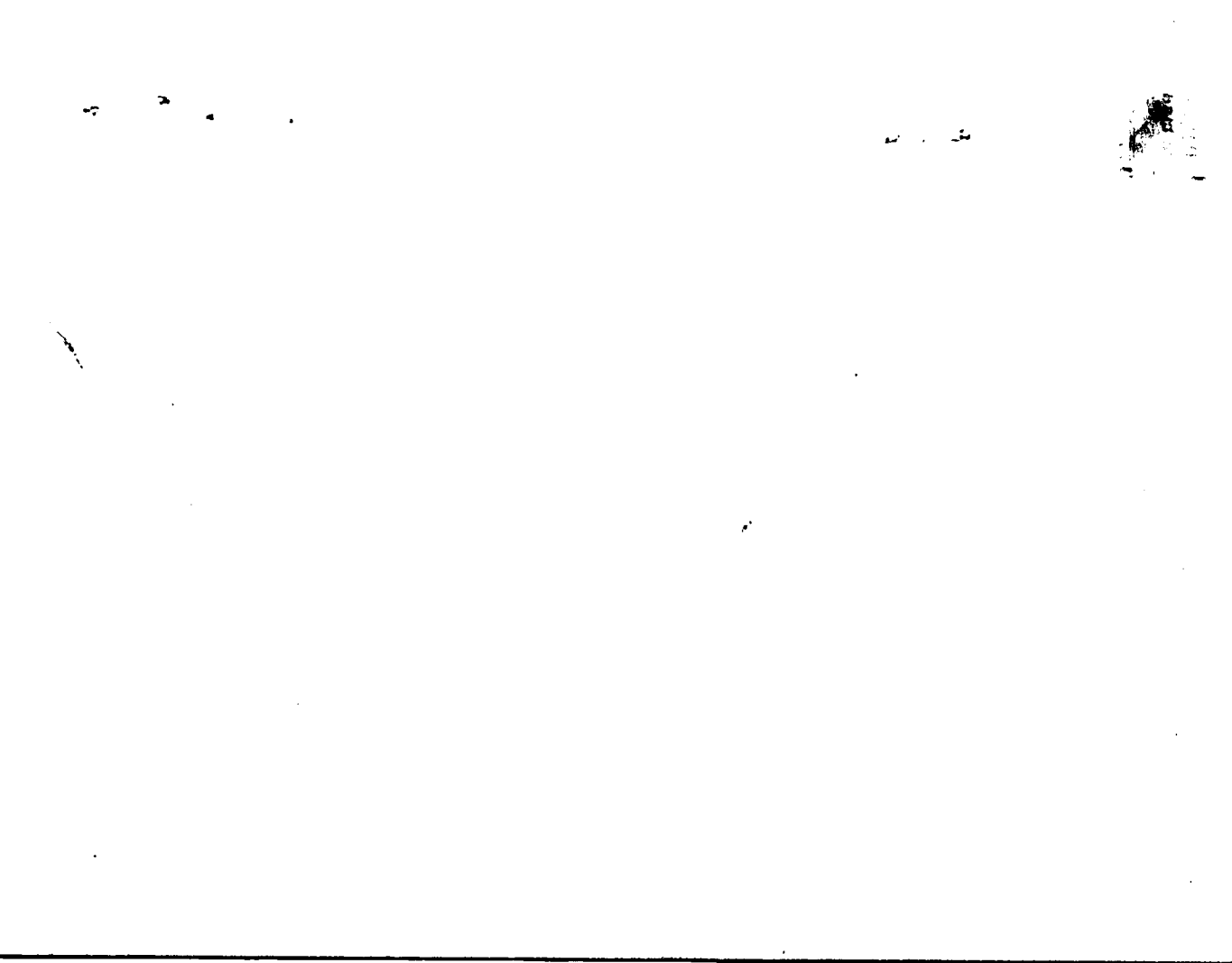
(Signature) L. M. Trischell

(Physician or midwife)

Address Parma Ida.

Filed 12-10 1928 Idaho Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH. Registration Dist. No. 3
County of Paria Primary Registration District No. 2007
City of Canyon (No. _____ St.)

5.
BOARD HEALTH
Bureau of Vital Statistics
File No. 63701
Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn (Dunn)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child
(Write the word.)

6. DATE OF BIRTH Nov. 27 1928
(Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day
yrs. mos. ds. how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho Canyon

10. NAME OF FATHER Richard D. Dunn

11. BIRTHPLACE OF FATHER
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Verda Stout

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wesley H. Dunn
(Address) Paria, Ida.

15. Filed 12-20 1928 Hubert Haldorf
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov. 27 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27 1928, to Nov. 27 1928
that I last saw h. Stillborn 1928
and that death occurred on the date stated above, at 59 M.
The CAUSE OF DEATH* was as follows:

Stillborn (Twins)
Cause not known
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. M. Mitchell M. D.
19 (Address) Paria, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Home DATE OF BURIAL 11-27 1928

20. UNDERTAKER None ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED DEC 9 1928

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S.

County of Canyon
City of Parma

CERTIFICATE OF BIRTH

186335

No. 45227-014-236 St.

Registration District No. 3

State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 2007 Local Registrar's No. 78

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other?	and	Number in order of birth	Legiti- mate	Date of birth <u>Nov 27, 1928</u>
	(To be answered only in event of plural births)			<u>yes</u>	(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? Stillborn

Number of child of this mother, including present birth 5 (a) Born alive and now living none

Born alive but now dead 3 Stillborn 2

FATHER
FULL NAME William G. Dunn

MOTHER
FULL MAIDEN NAME Verda Stout

Residence (Usual place of abode) Parma, Ida.

Residence (Usual place of abode) Parma, Ida.

If nonresident, give place and State

If nonresident, give place and State

Color or race White Age at last Birthday 29
(Years)

Color or race White Age at last Birthday 24
(Years)

Birthplace Idaho
(City and State or Country)

Birthplace Idaho
(City and State or Country)

Occupation Farmer

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5:30 A. M.
on the date above stated.

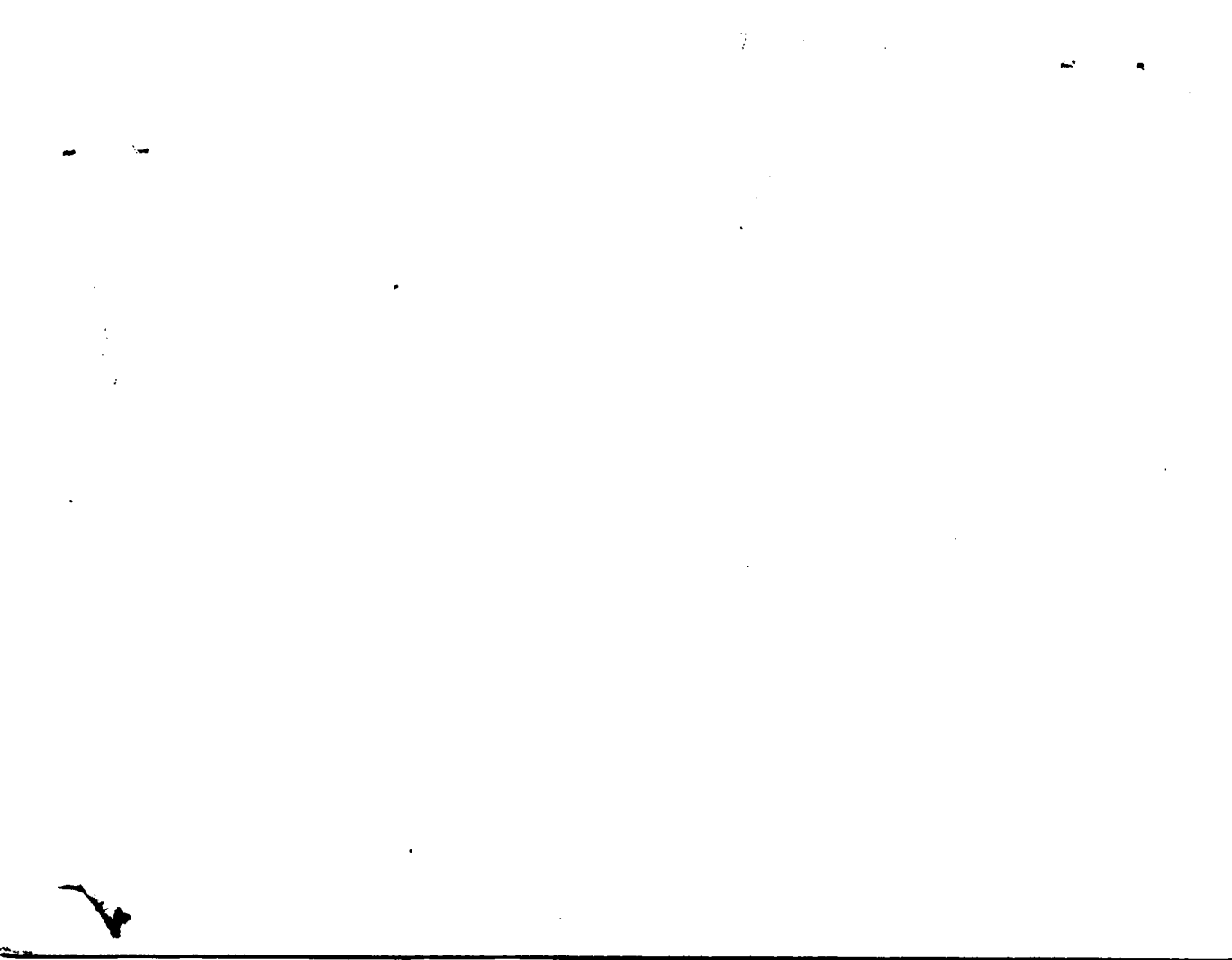
(Signature) W. Mitchell

(Physician or midwife)

Address Parma, Ida.

Filed 12-10-1928 W. Mitchell
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



OF DEATH.

Registration District No. 2
Primary Registration District No. 2007
(No. St.)

City of Canyon
Parma

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn (Dunn)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child of Twin (Write the word.)

6. DATE OF BIRTH Nov. 27 1928 (Month) (Day) (Year)

7. AGE Stillborn IF LESS than 1 day how many hrs. or min? yrs. mos. ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Canyon County Ida.

10. NAME OF FATHER Harold G. Dunn.

11. BIRTHPLACE OF FATHER Tenn. (State or Country)

12. MAIDEN NAME OF MOTHER Verda Stout.

13. BIRTHPLACE OF MOTHER Tenn. (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Willard G. Dunn (Address) Parma Ida.

15. Filed 12-29 1928 Willard G. Dunn Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov. 27 1928 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27 1928, to Nov. 27 1928 that I last saw Stillborn Twin and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Stillborn Twin Cause not known (Duration) yrs. mos. ds.

Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) D. M. Mitchell M. D. 19 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL House 11-27 1928

20. UNDERTAKER ADDRESS none

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

RECEIVED DEC 5 1928

PLACE OF BIRTH

225-223-014-313

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of anyon

City of Payson

No. _____ St. _____

Registration District No. 7

File No. 166341

Hospital _____

Primary Registration District No. 100

Registered No. 49

FULL NAME OF CHILD

Dolores Mae Stevens

(Certificate of no value without full name of child.)

Sex of Child

Female

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

yes

Date of
birth

Nov. 23, 1928

(Month)

(Day)

(Year)

What bacteriocidal solution was used in eyes? no

Number of child of this mother, including present birth 0

Number of child of this mother now living, including present birth 0

FULL
NAME

FATHER

Wayland C. Stevens

RESIDENCE

Payson Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

3.5
(Years)

BIRTHPLACE

Wisconsin

OCCUPATION

Banker

FULL
MAIDEN
NAME

MOTHER

Mary Ann Callaway

RESIDENCE

Payson Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

40
(Years)

BIRTHPLACE

Wisconsin

OCCUPATION

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was still born, at 5:30 PM M.
on the date above stated.

(Born alive or stillborn)

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

A. R. Meredith

(Physician or midwife)

Give names added from a supplemental report.

Address

Payson Idaho

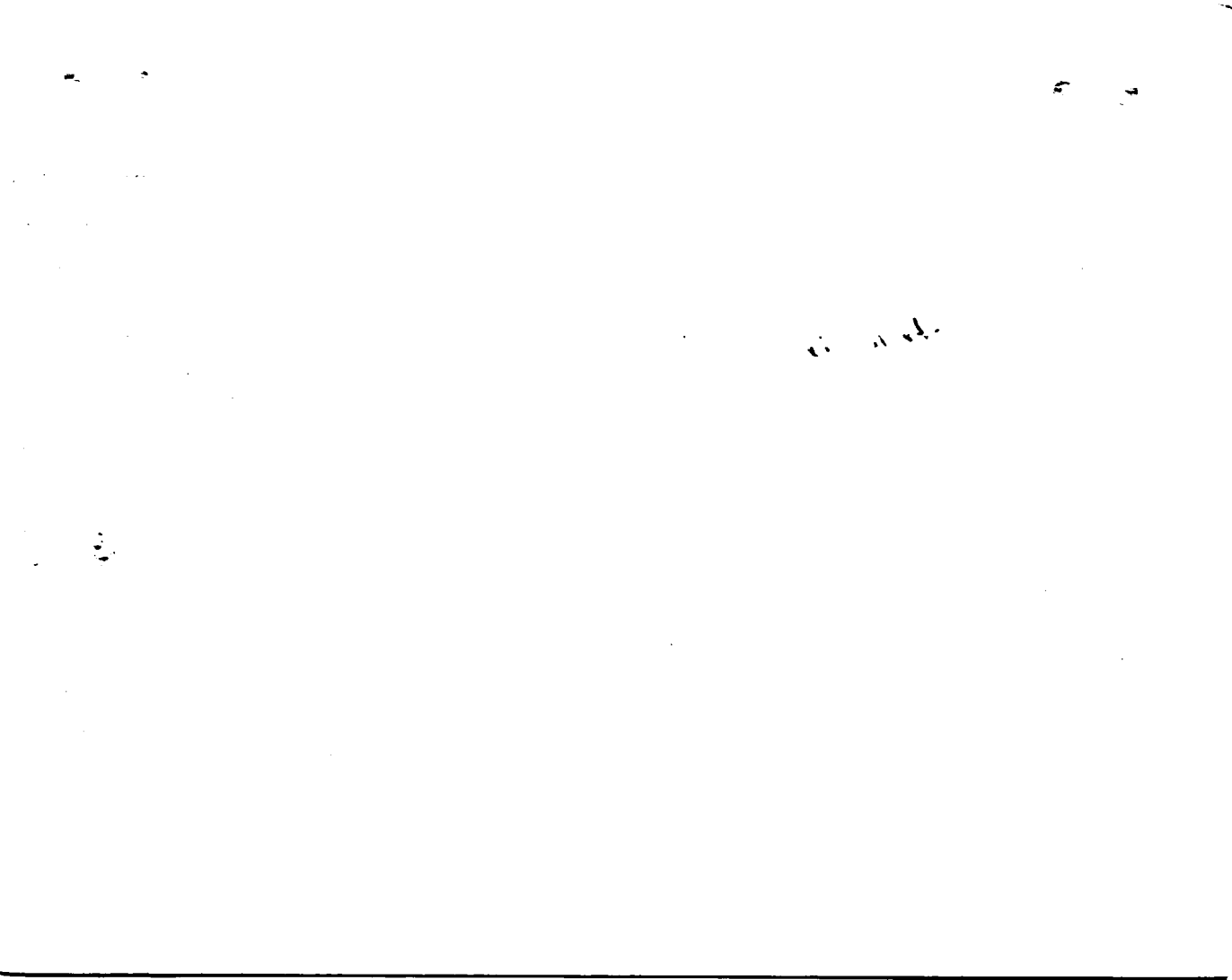
Filed

12-1-1928

Butter Conway

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 63707

County of Canyon

City of Nampa

Registration District No. 1

Primary Registration District No. 1006

Local Registrar's No. 32

(No. 1123 - 12th Ave. South)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No.

St.

(Usual place of abode)

Length of residence in city or town where death occurred.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced (write the word)

Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

November 23 - 1928

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)Nampa
Idaho

10. NAME OF FATHER

W.C. Stevens

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Jeanette Callaway

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Wisconsin

14.

Informant

Mr. W.C. Stevens

(Address)

Kuna, Idaho

15.

Filed

12-1

1928

Ferttha Conway

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 73

(Month)

(Day)

1928
(Year)

17. I HEREBY CERTIFY That I attended deceased from

at Birth

that I last saw her alive at Birth

and that death occurred, on the date stated above, at 5:00

m.

The CAUSE OF DEATH was as follows:

Still born

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Dr. Meredith

M. D.

11/24 1928 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Kuna - Idaho

11-25 1928

20. Undertaker

Address

Mrs. Nina M. Talley Nampa, Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

DEC 3 1928

STATE OF IDAHO

County of

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

City of

CERTIFICATE OF BIRTH

No. St.

384-212.016-719

Registration District No. State File No.

(If born in hospital or institution give name.)

Prim. Registration District No. Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <i>female</i>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mated	Date of birth <i>Oct. 12</i> 19 <i>28</i> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum *the*

Number of child of this mother, including present birth *2* (a) Born alive and now living *1*

Born alive but now dead *yes* Stillborn

FULL NAME *Hall Church* FATHER

FULL MAIDEN NAME *Edna Paidron* MOTHER

Residence (Usual place of abode) *Burley, Id.*

Residence (Usual place of abode) *Burley, Id.*

If nonresident, give place and State

If nonresident, give place and State

Color or race *white* Age at last Birthday *31* (Years)

Color or race *white* Age at last Birthday *31* (Years)

Birthplace *Utah* (City and State or Country)

Birthplace *Idaho* (City and State or Country)

Occupation *farmer*

Occupation *housewife*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at *S. A.* M. on the date above stated.

(Signature) *A. G. Nelson, M.D.*

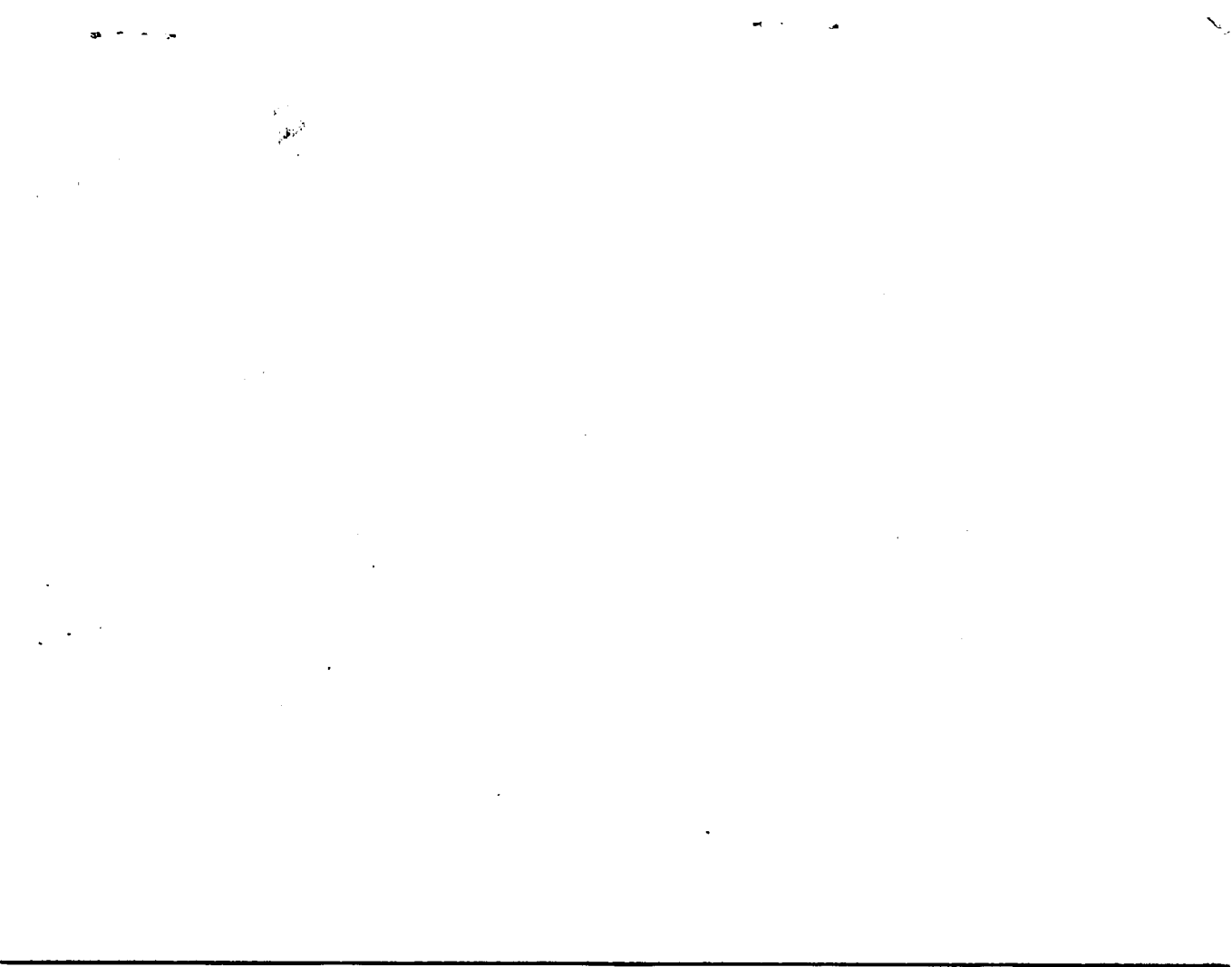
(Physician or midwife)

Address *Burley, Idaho*

Filed *19*

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 3 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **63716**

PLACE OF DEATH

County of

City of

Registration District No. **117**

Primary Registration District No. **2196**

Local Registrar's No. **4**

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Isaac Church**

(a) Residence. No. **Burley Id.** St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **male** 4 COLOR OR RACE **white** 5 Single, Married, Widowed, or Divorced (write the word) _____

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) **Oct 12 - 1928**

7 AGE Years Months Days 1 If LESS than day, hrs. or min. **28 06 12**

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) **Burley Idaho**
(State or country)

10 NAME OF FATHER **Hall Church**

11 BIRTHPLACE OF FATHER (city or town) **Idaho**
(State or country)

12 MAIDEN NAME OF MOTHER **Edna Paulson**

13 BIRTHPLACE OF MOTHER (city or town) **Idaho**
(State or country)

14 Informant **Hall Church**
(Address) **Burley Id.**

15 Filed **Dec 1, 1928** **Dr. H. C. Butler** Registrar
W. B. Greco

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **Oct 12 1928**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,
that I last saw him alive on _____, 19____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
not known, probably premature
separation of placenta of mother
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) _____
(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?
(Signed) **W. B. Greco** M. D.
112, 19**28** (Address) **Burley Id.**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal _____ Date of Burial _____
19

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

365-779-021-595

PLACE OF BIRTH

RECEIVED DEC 8 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

County of Franklin
City of Preston, Ida
No. _____ St.

Registration District No. 27 State File No. 166427

(If born in hospital or institution
give name.)

Prim. Registration District No. 2119 Local Registrar's No. 294

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	<input checked="" type="checkbox"/> Twin <input type="checkbox"/> Triplet <input type="checkbox"/> or other	<input checked="" type="checkbox"/> and <input type="checkbox"/> Number in order of birth	<input type="checkbox"/> Legitimate?	Date of birth <u>Nov 16 1928</u> (Month) (Day) (Year)
(To be answered only in event of plural births)				

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Earl Condie
Residence (Usual place of abode) Preston, Ida
If nonresident, give place and State _____
Color or race White Age at last Birthday 29 (Years)
Birthplace Preston, Ida
(City and State or Country)
Occupation Farmer

MOTHER
FULL MAIDEN NAME Lettie Nielson
Residence (Usual place of abode) Preston, Ida
If nonresident, give place and State _____
Color or race White Age at last Birthday 34 (Years)
Birthplace Cleveland, Ida
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was ☒ Born alive ☐ Stillborn at 6:25 A. M.
on the date above stated.

(Signature) G. W. Stutes

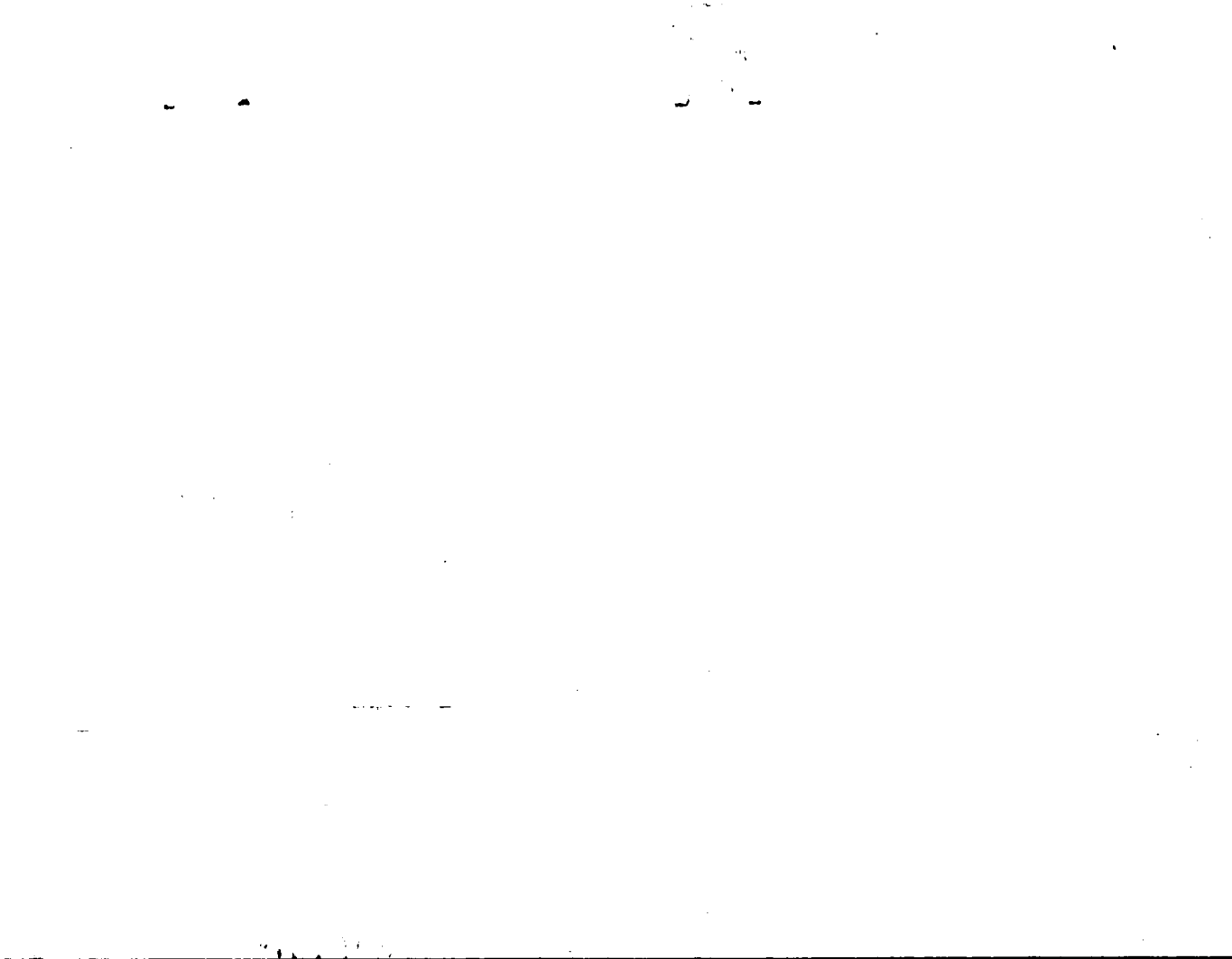
(Physician or midwife)

Address Preston, Ida

Filed Dec. 4 1928 R. P. Cutler

Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 8 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 63738

PLACE OF DEATH

County of Franklin

City of Preston, Ida

CERTIFICATE OF DEATH

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No. 48

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6. DATE OF BIRTH (month, day and year) Nov 19-1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED Still

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Preston, Ida (State or country)

10. NAME OF FATHER Fern Condie

11. BIRTHPLACE OF FATHER (city or town) Preston, Ida (State or Country)

12. MAIDEN NAME OF MOTHER Lettie Nielsen

13. BIRTHPLACE OF MOTHER (city or town) Cleveland, Ida (State or Country)

14. Informant (Address)

15. Filed Dec. 4, 1928

A. R. Curley
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 19, 1928 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19, 1928, to Nov 19, 1928, that I last saw him alive on Nov 19, 1928, and that death occurred, on the date stated above, at 9 a. m. The CAUSE OF DEATH was as follows:

Infant born dead—Caused by pressure on cord before birth.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. W. States, M. D. Nov 20, 1928 (Address) Preston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Preston, Ida Date of Burial Nov 21 1928

20. Undertaker Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each
and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

County of Latah

City of Moscow

No. St. Jackson St.

Registration District No. 61

File No. 166514

Hospital Inland Empire

Primary Registration District No. 1011

Registered No. 133

FULL NAME OF CHILD

Baby Sessions

(Certificate of no value without full name of child.)

Sex of Child male

Twin
Triplet
or other?

and

Number
in order
of birth

Legiti-
mate?

yes

Date of
birth

Nov-20th 1928

(Month)

(Day)

(Year)

What bacterioidal solution was used in eyes?

Ag. No. 3

Number of child of this mother, including present birth... 3

Number of child of this mother now living, including present birth... 2

FULL
NAME

FATHER

J. Wyley Sessions -

RESIDENCE

Moscow Idaho

COLOR

White

AGE AT LAST
BIRTHDAY

42
(Years)

BIRTHPLACE

Idaho

OCCUPATION

University Instructor

FULL
MAIDEN
NAME

MOTHER

Magdalen Funk

RESIDENCE

Moscow Idaho

COLOR

White -

AGE AT LAST
BIRTHDAY

38
(Years)

BIRTHPLACE

Utah

OCCUPATION

Hwp

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn 2 P M.
on the date above stated.

*When there was no attending physician or
midwife, then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

C. J. Magee
m. d.

(Physician or midwife)

Give names added from a supplemental report.

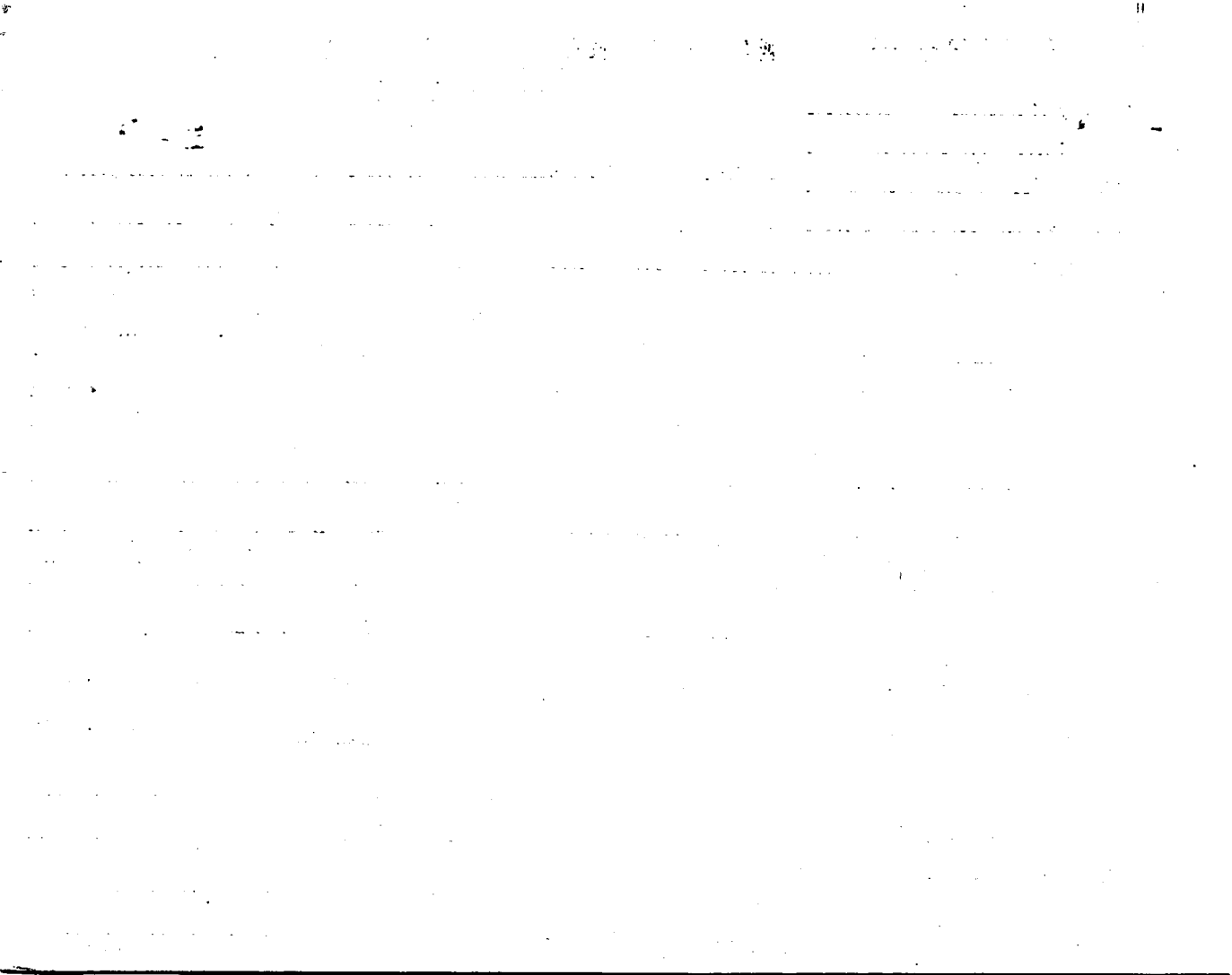
Address

Filed

Dec 4 1928 Willcoxithers

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

County of Latah

Primary Registration District No. 1011

File No. 63700

City of MOSCOW

(No. _____, _____ St.)

Registered No. 62

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME BABY SESSIONS

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Child
(Write the word.)

6. DATE OF BIRTH

Nov. 20 1928
(Month) (Day) (Year)

7. AGE

0 yrs. 0 mos. 0 ds.

IF LESS than 1 day
has any _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) MOSCOW

10. NAME OF FATHER

J. Wyley Sessions

11. BIRTHPLACE OF FATHER

(State or Country) Marion Idaho

12. MAIDEN NAME OF MOTHER

Magalen Funk

13. BIRTHPLACE OF MOTHER

(State or Country) St. George, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Wyley Sessions

(Address) Moscow Ida.

15.

Filed Nov 20 1928 W. H. Kearney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 20 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to Nov 20 1928

that I last saw h. _____ alive on _____ 191

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still-born - Placenta Praevia with intra + extra uterine bleeding. Child died from hemorrhage thru placenta.

Contributory (Secondary)

Placenta Praevia

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. D.

11/20 1928 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted, _____

If not at place of death? _____

Former or _____

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Moscow Ida.

DATE OF BURIAL

Nov. 20 1928

20. UNDERTAKER

F. R. Short

ADDRESS

Moscow

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2320.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

693-103-233-236

PLACE OF BIRTH

NOV 15 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of Madison
City of Rexburg
No. 70-8-21 Main St.

Registration District No. 100 State File No. S 166613(If born in hospital or institution
give name.)Prim. Registration District No. 2178 Local Registrar's No. 261FULL NAME OF CHILD Steelborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in case of plural births)	and {	Number in order of birth (To be answered only in case of plural births)	Legiti- mate? <u>Yes</u>	Date of birth <u>Nov 3</u> 19 <u>28</u> (Month) (Day) (Year)
--------------------------	--	-------	--	-----------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? noneNumber of child of this mother, including present birth 1 (a) Born alive and now living noneBorn alive but now dead one Stillborn yes

FATHER
FULL NAME Louis Allen Wilson
Residence (Usual place of abode) Archer

MOTHER
FULL MAIDEN NAME Ella May Stocks
Residence (Usual place of abode) Archer

If nonresident, give place and State ✓If nonresident, give place and State ✓Color or race White Age at last Birthday 25Color or race White Age at last Birthday 25Birthplace Archer, Idaho (City and State or Country)Birthplace Idaho (City and State or Country)Occupation FarmerOccupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 1645 P. M. on the date above stated.(Signature) Louis A. Rich

(Physician or)

Address Rexburg, IdahoFiled 11/10 1928 W. J. Young

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Registration District No. 100
Prin. Registration District No. 100

made? Legit.

[illegible]

10-3025
b1b1c

W hat prophylactic was used to prevent *Opisthorchis* contamination?

Number of child of all mother including present birth

HELIAH

NAME
MADISON
JULY

(shown to said land); enclosed

Reference (1) will place it in context.

CONFIDENTIAL

_____ Are at last Biting

... 92442718

(City and State of Country)

containing:

to state and country)

ORIGINATOR OF ATTENDING PHYSICIAN OR MEDICINE

1 hereby certify that I attended the birth of this child, who was a full-term

on: as date above sub: no.

(b)(7)(D)

There were no attending physicians, and the father, householder, and wife, then the mother, should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

THESE PLANTS WITH ONLY ONE YEAR TO GROW TO BEAR FRUIT ARE NOT AS VALUABLE AS THE PLANTS WHICH TAKE TWO YEARS TO GROW TO BEAR FRUIT. THE PLANTS WHICH TAKE TWO YEARS TO GROW TO BEAR FRUIT ARE THE MOST VALUABLE OF ALL.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1928

PLACE OF DEATH

County of Madison

City of Rexburg

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

(No. Dr. Rich Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 63801

Local Registrar's No. 64

2. FULL NAME Baby Wilcox.

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Babe

6. DATE OF BIRTH (month, day and year) Nov 3, 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min. 0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Babe

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho. (State or country)

10. NAME OF FATHER

Leas Allen Wilcox.

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

Idaho.

12. MAIDEN NAME OF MOTHER

Ellen May Stocks.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

Utah.

14. Informant Mrs E. M. Stocks.

(Address) Rexburg, Idaho.

15. Filed 11/7, 19 28 J. C. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11-3-28
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11-3-28 to 11-3-28, 19 28

that I last saw him alive on dead 11-3-28, 19 28

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Unassisted Parturition.
(premature birth).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Nephritis of Mother

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) K. R. Rich, M. D.

11-4-28, 19 28 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Archery Idaho 11/7/28 19 28

20. Undertaker Address

W. B. E. Church Rexburg

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

689-229-034-133
PLACE OF BIRTH

County of Idaho
City of Rupert
No. _____ St. _____

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 166629

Registration District No. 19 State File No. _____

Prim. Registration District No. 2015 Local Registrar's No. 193

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>fe</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>yes</u>	Date of birth <u>11-29</u> (Month) (Day) (Year) <u>1928</u>
------------------------	---	--------------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? Yes. Silver 1570

Number of child of this mother, including present birth 5 (a) Born alive and now living 5

Born alive but now dead 0 Stillborn 0

FATHER	MOTHER
FULL NAME <u>Clarence C. Whitehead</u>	FULL MAIDEN NAME <u>May Belle Allen</u>

Residence (Usual place of abode) Rupert Ida

If nonresident, give place and State _____

Color or race white Age at last Birthday 41 (Years)

Birthplace Richmond, Utah (City and State or Country)

Occupation Farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 9 15 a M. on the date above stated. { Stillborn }

(Signature) [Signature]

(Physician or midwife)

Address Rupert Ida

Filed 12-4 19 28 [Signature]

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

NOV

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

819-113-036-964
PLACE OF BIRTH

County of Malad RECEIVED DEC 6 1928
City of Malad

No. St.

Community Hospital

(If born in hospital or institution
give name.)

Registration District No. 26 State File No. 66638

Prim. Registration District No. 269 Local Registrar's No. 170

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Nov. 13 1928</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? argyrol

Number of child of this mother, including present birth 2 (a) Born alive and now living one

Born alive but now dead one Stillborn yes

FATHER
FULL NAME Lerrin R. Harris

Residence (Usual place of abode) Malad

If nonresident, give place and State

Color or race White Age at last Birthday 28 (Years)

Birthplace Portage, Utah (City and State or Country)

Occupation Sales Clerk

MOTHER
FULL MAIDEN NAME Ruth Roderick

Residence (Usual place of abode) Malad

If nonresident, give place and State

Color or race White Age at last Birthday 22 (Years)

Birthplace Lamar, Idaho (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn } at 12:35 P. M.
on the date above stated.

(Signature) [Signature]

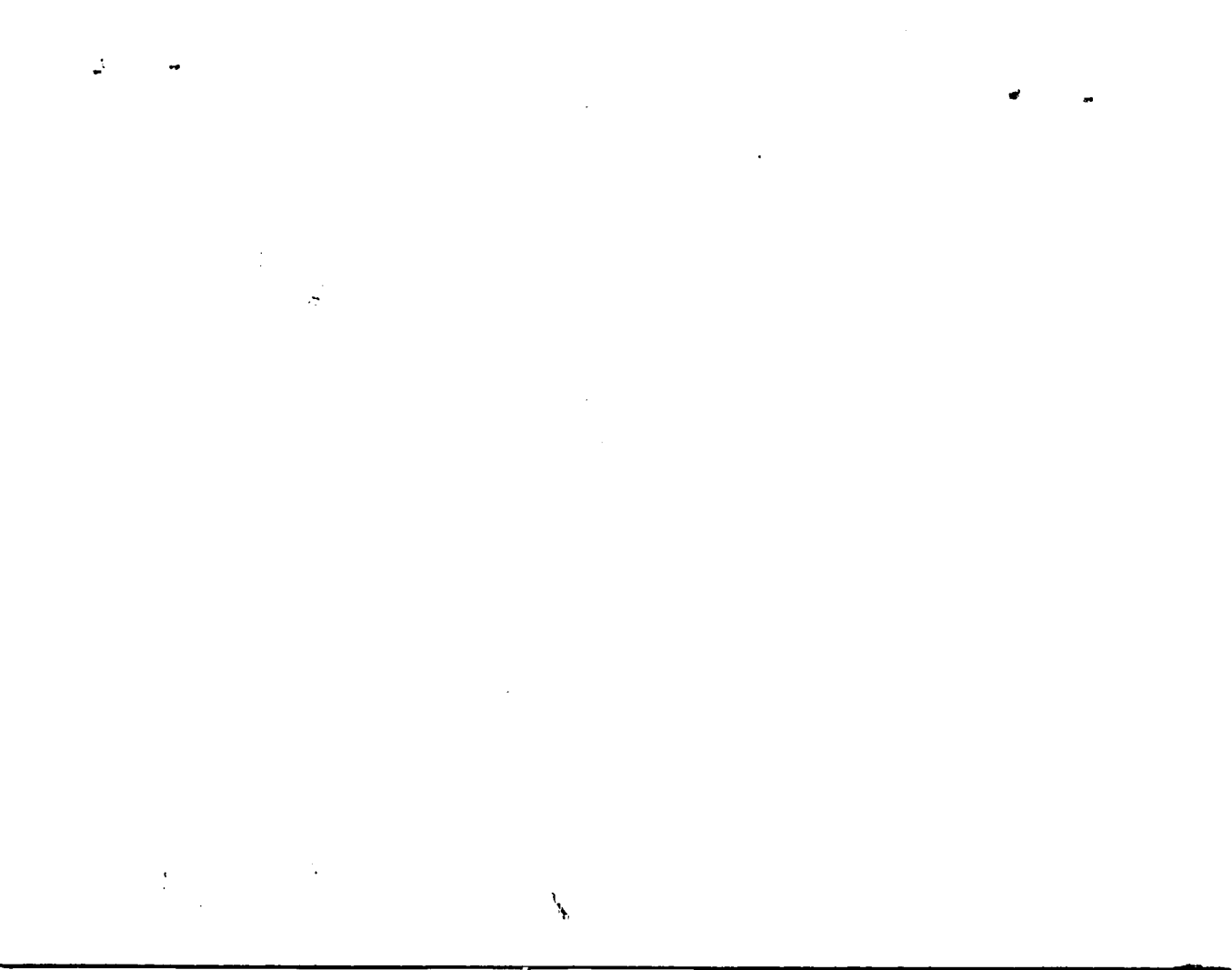
(Physician or midwife)

Address Malad

Filed 11/30 19 28 J. M. Turner

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

DEC 6 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **63809**

PLACE OF DEATH

County of Brida
City of Malad

Registration District No. 26
Primary Registration District No. 2069

Local Registrar's No. 64

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Still born

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 18-18

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Malad Idaho
(State or country)

10. NAME OF FATHER Jesse Harris

11. BIRTHPLACE OF FATHER (city or town) Portage
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Ruth A. Roderick

13. BIRTHPLACE OF MOTHER (city or town) Samaria
(State or Country) Idaho

14. Informant John P. Roderick
(Address) Samaria Ida

15. Filled 11/30, 1928 J. M. Keras
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 13 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at..... m.
The CAUSE OF DEATH was as follows:
Still born

CONTRIBUTORY
(Secondary)

18. Where was disease contracted
if not at place of death?
Did an operation precede death?..... Date of.....
Was there an autopsy?.....

What test confirmed diagnosis?
(Signed) W. M. Walker
11/13, 1928 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Portage Utah Date of Burial Nov. 13 1928

20. Undertaker J. Guy Benson Address Malad Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill;** (a) **Salesman, (b) Grocery;** (a) **Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home;** and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

235-230-2041-319
PLACE OF BIRTH - D DEC 3 1928

County of Idaho
City of Driggs
No. _____ St. _____

1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

Registration District No. 77 State File No. 166669
Prim. Registration District No. 2176 Local Registrar's No. 47

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other <u>One</u>	and {	Number in order of birth <u>1</u>	Legiti- mate? <u>yes</u>	Date of birth <u>10</u> <u>30</u> <u>1928</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

What prophylactic was used to prevent Ophthalmia Neonatorum? yes

Number of child of this mother, including present birth 1 (a) Born alive and now living —

Born alive but now dead yes Stillborn yes

FATHER FULL NAME <u>C. H. Stephens</u>	MOTHER FULL MAIDEN NAME <u>Marie Lewis</u>
---	---

Residence (Usual place of abode) Driggs, Ida. Residence (Usual place of abode) Driggs, Ida.

If nonresident, give place and State _____ If nonresident, give place and State _____

Color or race White Age at last Birthday 21 Color or race White Age at last Birthday 22
(Years) (Years)

Birthplace Dushville, Ill. Birthplace Driggs, Ida.
(City and State or Country) (City and State or Country)

Occupation Walter 9 Coal Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 5 P. M.
on the date above stated.

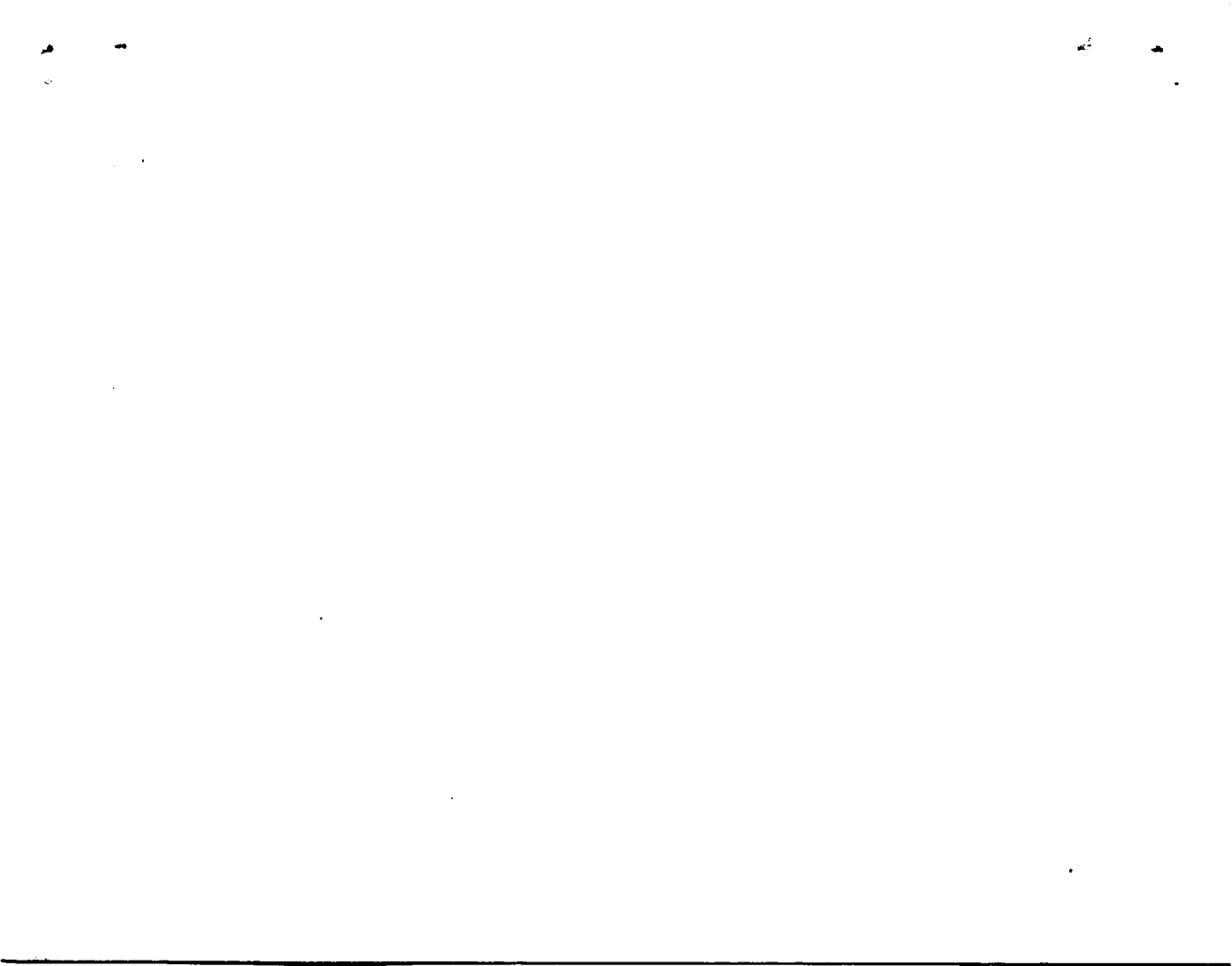
(Signature) Dr. Markinson

Physician
(Physician or midwife)

Address Driggs, Ida.

Filed 11-28- 1928 Martha Marker
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECORDED DEC 3 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 63827

PLACE OF DEATH

County of TetonCity of DriggsRegistration District No. 77Primary Registration District No. 2176Local Registrar's No. 8(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Bertha Louise Stephens

(a) Residence. No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Driggs, Idaho
(State or country)10. NAME OF FATHER Karl Homer Stephens11. BIRTHPLACE OF FATHER (city or town) Ill.
(State or Country)12. MAIDEN NAME OF MOTHER Marie Lewis13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)14. Informant Mrs. C. H. Stephens
(Address) Driggs Idaho15. Filled 11-27-, 1928 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 30 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-30-, 1928, to 10-30, 1928that I last saw him alive on _____, 1928and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Still born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) Dr. Robinson, M. D.10-30, 1928 (Address) Driggs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Driggs, Cemetery Oct 30- 1928

20. Under _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

415-2067 RECEIVED JAN 7 1929
 205-489 PLACE OF BIRTH

Form V. S. No. 11-25m-4-14-18

STATE OF IDAHO
 BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

166881

S

County of PerevalCity of Idaho

No. _____ St. _____

Registration District No. 31File No. 31

Hospital _____

Primary Registration District No. _____

Registered No. _____

Full Name of Child

Unnamed Davenport

SEX OF CHILD

71Twin
Triplet
or other?{ and } Number
in order
of birth
(To be answered only in event of plural births)Legiti-
mate?yesDATE OF
BIRTHDec 6 18
(Month) (Day) (Year)FULL
NAMEFATHER
Simon DavenportFULL
MAIDEN
NAMEMOTHER
Lula Morda

RESIDENCE

Pereval Co Idaho

RESIDENCE

Pereval Co Idaho

COLOR

IndianAGE AT LAST
BIRTHDAY21
(Years)

COLOR

IndianAGE AT LAST
BIRTHDAY21
(Years)

BIRTHPLACE

Coudale Reserve

BIRTHPLACE

Mountain Flathead

OCCUPATION

Farmer

OCCUPATION

IdahoNumber of child of this mother, including present birth. 1Number of children of this mother now living, including present birth. 2

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was _____, at _____, on the date above stated.

(Born alive or stillborn)

10 P

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. A. Nelson

(Physician or midwife)

Given names added from a supplemental report.

19

Address

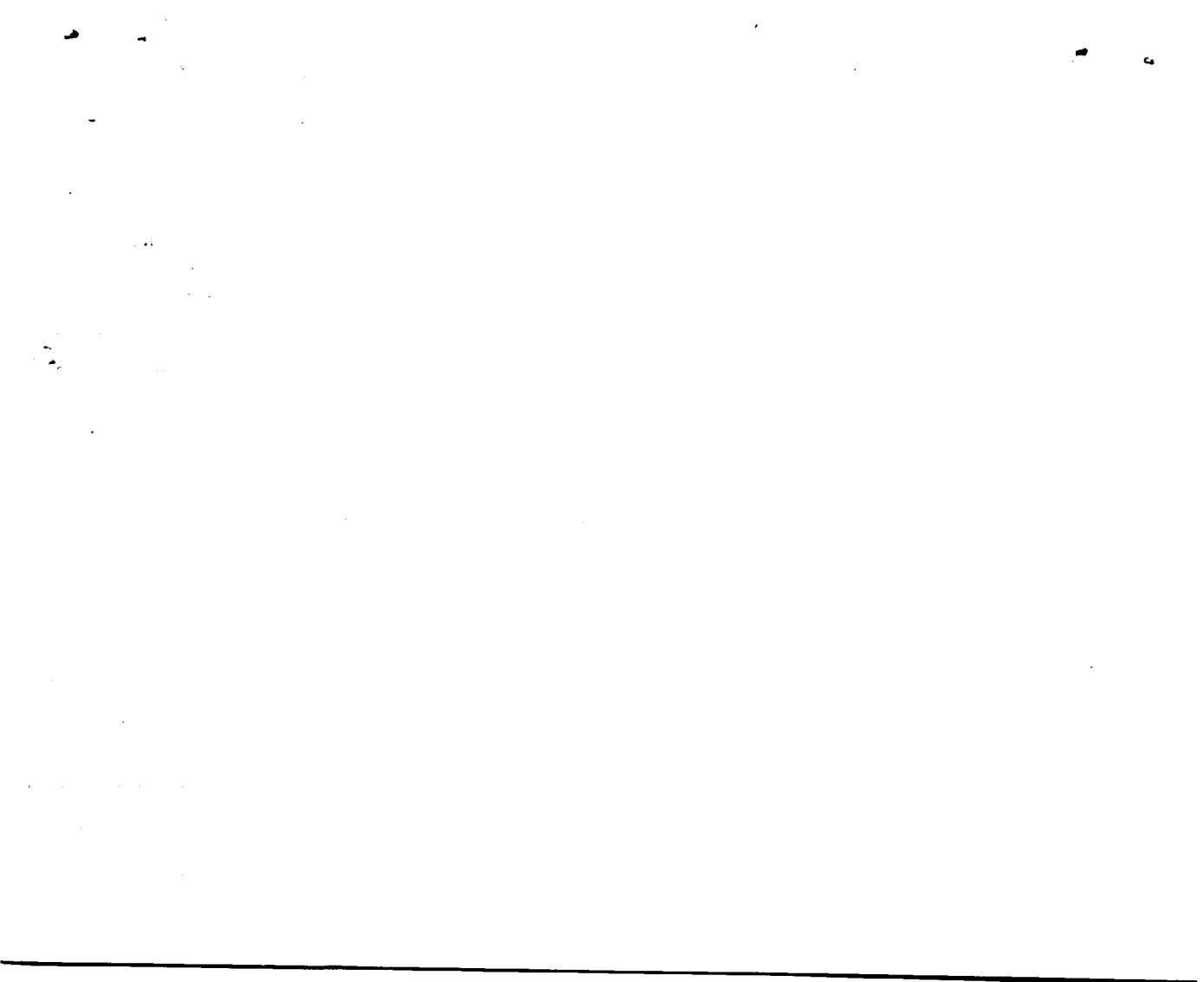
Teton Wash

Filed

Dec. 11 1925

Registrar

John Post
Registrar



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. See instructions on back of certificate.

RECEIVED JAN 7 1929

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

(63956)

1 PLACE OF DEATH
County Pemuevok State Idaho Registered No. 63956-18
Township _____ or Village _____
City Letimet No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Unnamed Davenport
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 71 4 COLOR OR RACE Indian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Dec 6 - 28

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, --- hrs. or --- min. Still born

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Pemuevok Co
(State or country)

10 NAME OF FATHER Seymour Davenport

11 BIRTHPLACE OF FATHER (city or town) C.O.D.
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Lula Morris

13 BIRTHPLACE OF MOTHER (city or town) Flathead
(State or country) Mont.

14 Informant Simon Davenport
(Address) Letimet, Idaho

15 Filed Dec. 8, 1928 John Post
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Still born 19 28

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h_____ alive on _____, 19____,

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

Premature

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. A. Nelson M. D.

Address Letimet, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CRÉMATION, OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cardiopsind fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptom-

atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Insanitation," "Marasmus," "Old age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

168-222-206-293 PLACE OF BIRTH <i>Warrent</i>		STATE OF IDAHO DEPARTMENT OF PUBLIC WELFARE BUREAU OF VITAL STATISTICS		November 1928	
RECEIVED JAN 8 1929 County of <i>Ft. Hall Reservation</i>		S			
City of <i>State Idaho.</i>		CERTIFICATE OF BIRTH 166896			
No.		St. Registration District No. 121		State File No.	
Hospital <i>H. Hall Agency</i>		Primary Registration District No. 2194		Local Registrar's No. 407	
FULL NAME OF CHILD <i>Jane Johnson</i>					
(Certificate of no value without full name of child)					
Sex of Child <i>Female</i>		Twin <i>Yes</i> Triplet or other? <i>Yes</i>		and { Number in order of birth <i>I-st</i> }	
		(To be answered only in event of plural births)		Legitimate? <i>Yes</i>	
				Date of birth <i>Nov. 22</i> 1928	
				(Month) (Day) (Year)	
What bactericidal solution was used in eyes?					
Number of child of this mother, including present birth 0 Number of child of this mother now living, including present birth 0					
FULL NAME FATHER <i>Horace Johnson</i>			FULL MAIDEN NAME MOTHER <i>Josephine Willett</i>		
RESIDENCE <i>Ft. Hall Reservation</i>			RESIDENCE <i>Ft. Hall Reservation</i>		
COLOR <i>Shoshone</i> <i>Ind. 4/4</i>			COLOR <i>Shoshone Ind. 4/4</i>		
AGE AT LAST BIRTHDAY <i>23</i> (Years)			AGE AT LAST BIRTHDAY <i>20</i> (Years)		
BIRTHPLACE <i>Lemhi Reservation</i>			BIRTHPLACE <i>Ft. Hall Reservation</i>		
OCCUPATION			OCCUPATION		
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*					
I hereby certify that I attended the birth of this child, who was <i>Stillborn</i> at <i>3:15</i> P. M. on the date above stated.					
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.					
Give names added from a supplemental report.					
<i>Dec. 28</i> , 1928					
Address <i>Ft. Hall, Idaho.</i>					
Filed <i>Dec. 28</i> 1928 <i>Mrs. Louise E. Lubie</i>					
Registrar. Registrar.					



Current complete

November 1928

RECEIVED JAN 8 1929

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 63963

County of Ft. Hall Reservation, Idaho. CERTIFICATE OF DEATH

City of _____

Registration District No. 121Primary Registration District No. 2194Local Registrar's No. 194(No. Ft. Hall Agency Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jane Johnson.

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Shoshone
Ind. 4/45. Single, Married, Widowed,
or Divorced (write the word)Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

Nov. 22, 1928

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or
min.000

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(Unborn)(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Ft. Hall Reservation
(State or country)

10. NAME OF FATHER

Horace Johnson11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Lemhi Reservation

12. MAIDEN NAME OF MOTHER

Josephine Willett13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Ft. Hall Reservation14. Informant Horace Johnson(Address) Ft. Hall Reservation15. Dec. 28 1928 Mrs. Walter E. Palmer

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 22, 1928

(Month)

(Day)

19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov. 22 1928, to Nov 28 1928,
Birththat I last saw Birth alive on _____, 19____and that death occurred, on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH* was as follows:

Stillborn due to flu and
Broncho Pneumonia of the mother(duration) _____ yrs. _____ mos. 5 ds.

CONTRIBUTORY

(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? _____Did an operation precede death? No Date of _____Was there an autopsy? NoWhat test confirmed diagnosis? Birth of child(Signed) Harry P. Wheeler, M. D.19____ (Address) Ft. Hall, Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Ft. Hall Reservation Nov. 23, 1928

20. Undertaker

Brown, Eldredge, Blackfoot, Ida.

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

168-122-066-693 Current complete November 1928
PLACE OF BIRTH RECEIVED JAN 8 1929 STATE OF IDAHO
County of Ft. Hall Reservation DEPARTMENT OF PUBLIC WELFARE
City of State Idaho BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH 166897
No. H. Hall Agency Hospital St. Registration District No. 121 State File No. 166897
(If born in hospital or institution give name.) Prim. Registration District No. 2194 Local Registrar's No. 428
FULL NAME OF CHILD Jim Johnson
(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child Male Twin Yes and Number in order of birth 2-nd Legiti- Yes Date of birth Nov. 22 1928
(To be answered only in event of plural births) (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum?
Number of child of this mother, including present birth 2 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 2
FATHER MOTHER
FULL NAME Horace Johnson FULL MAIDEN NAME Josephine Willett
Residence (Usual place of abode) Ft. Hall Resv'n Residence (Usual place of abode) Same
If nonresident, give place and State If nonresident, give place and State
Color or race Shoshone Ind. Age at last Birthday 23 Color or race Shoshone Ind. Age at last Birthday 20
(Years) (Years)
Birthplace Lemhi Reservation Birthplace Ft. Hall Reservation
(City and State or Country) (City and State or Country)
Occupation Farming Occupation Housewife
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was { Stillborn } at 4:30 P. M.
on the date above stated.
(Signature) Henry P. Wheeler
(Physician or midwife)
Address Ft. Hall, Idaho.
Filed Dec. 28, 29 Mrs. Wallace E. Fathie
Registrar.

100-10000-11-1
100-10000-11-1

61

100-10000-11-1
100-10000-11-1

100-10000-11-1
100-10000-11-1

100-10000-11-1
100-10000-11-1

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1929 complete

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

November 1928

DO NOT WRITE IN THIS SPACE

State File No. 63964

PLACE OF DEATH

County of **Ft. Hall Reservation**
Idaho.

Registration District No. **121**

City of _____

Primary Registration District No. **2194**

Local Registrar's No. **195**

(No. **Ft. Hall Agency Hospital**)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Jim Johnson.**

(a) Residence. No. **Ft. Hall, Idaho.** St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Shoshone
Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word)

Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) **Nov. 22, 1928**

7. AGE

Years

Months

Days

If LESS than 1 day,
hrs. or
min.

0

0

0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Unborn

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **Ft. Hall Reservation**
(State or country)

10. NAME OF FATHER

Horace Johnson

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Lemhi Reservation

12. MAIDEN NAME OF MOTHER

Josephine Willett

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Ft Hall Reservation

14. Informant **Horace Johnson**

(Address)

Ft. Hall, Idaho

15. Filled

Dec. 28, 1928

Mr. Walter E. Pulice
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 22, 1928

(Month)

(Day)

19
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 22, 19**28**, to **Nov. 22, 1928**

that I last saw him alive on

Birth

and that death occurred, on the date stated above, at **4:30P** m.

The CAUSE OF DEATH* was as follows:

Stillborn due to flu and

Broncho of the mother9 pneumonia)

(duration) yrs. mos. **5** ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? ---

Did an operation precede death? **No** Date of _____

Was there an autopsy? **No**

What test confirmed diagnosis? **Birth of child**

(Signed) **Henry P. Wheeler**, M. D.

19. (Address) **Ft. Hall, Ida.**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Ft. Hall Reservation

Nov. 23, 1928

20. Undertaker

Brown, Eldredge, Blackfoot.

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

119-124206-878
PLACE OF BIRTH RECEIVED JAN 8 1929
County of Bingham
City of Shelley
No. _____ St. _____
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
Registration District No. 121 State File No. 166904
(If born in hospital or institution give name.)
Prim. Registration District No. 2194 Local Registrar's No. 466
FULL NAME OF CHILD Baby Murphy
(If stillborn, substitute the word "Stillbirth" for name of child)
Sex of Child Male Twin Triplet or other? and Number in order of birth 1 Legitimate? yes Date of birth 12-24-1928
(To be answered only in event of plural births) (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? None
Number of child of this mother, including present birth 6th (a) Born alive and now living one
Born alive but now dead 5 Stillborn five
FULL NAME FATHER Clyde E. Murphy FULL MAIDEN NAME MOTHER Mary J. Hagbr.
Residence (Usual place of abode) Shelley Residence (Usual place of abode) Shelley
If nonresident, give place and State _____ If nonresident, give place and State _____
Color or race white Age at last Birthday 31 Color or race white Age at last Birthday 30
Birthplace Endicott Neb. (Years) Birthplace Burlington Neb. (Years)
(City and State or Country) (City and State or Country)
Occupation Laborer Occupation Laundress

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

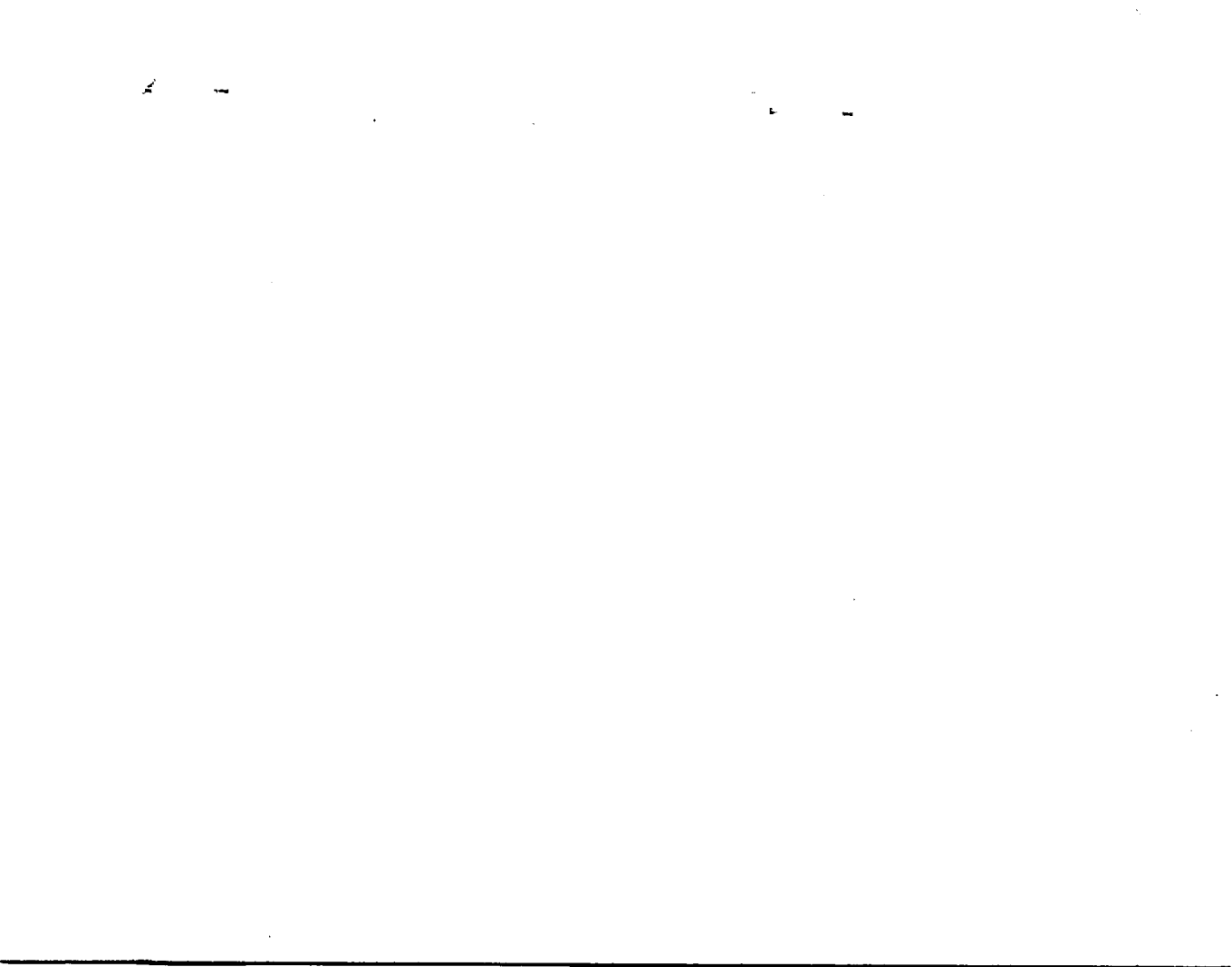
I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 4 a. M. on the date above stated.

(Signature) Edwin Carter M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Shelley, Ida.

Filed Dec 31 1928 Mrs. Walter E. Sathie
Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. **63988**

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 131
Primary Registration District No. 2194

Local Registrar's No. 222

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Murphy

(a) Residence. No. Shelley Idaho St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of None

6. DATE OF BIRTH (month, day and year) 12-24-1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
Still born 12 24 0 0 0

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Still born.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Shelley Idaho
(State or country)

10. NAME OF FATHER Clyde Murphy

11. BIRTHPLACE OF FATHER (city or town) Nebraska
(State or Country)

12. MAIDEN NAME OF MOTHER Mary J. Murphy

13. BIRTHPLACE OF MOTHER (city or town) Nebraska
(State or Country)

14. Informant Clyde Murphy
(Address) Shelley Idaho

15. Filed Dec 24 1928 Mr. Walter E. Fisher
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 24 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Still born to born, 19____
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Infant to take Wagon
test soon as mother has left
5 children at birth
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin Cullen, M. D.

12-24-1928 (Address) Shelley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Shelley Cemetery 12-24 1928

20. Undertaker Address

None employed

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed of given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED

JAN 8 1929

PLACE OF BIRTH

STATE OF IDAHO

County of Bingham
City of Pingree

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

166907

No. 386-105-006-649 St.

Registration District No. 121 State File No.

(If born in hospital or institution give name.)

Prim. Registration District No. 2194 Local Registrar's No. 469

FULL NAME OF CHILD Stillborn Thompson
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u>Yes</u>	and {	Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec 5</u> 19 <u>28</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? argyrol

Number of child of this mother, including present birth 8 (a) Born alive and now living 6

Born alive but now dead 2 Stillborn 1 this one

FATHER
FULL NAME Hyd C. Thompson

MOTHER
FULL MAIDEN NAME Edith Letrista Furness

Residence (Usual place of abode) Pingree

Residence (Usual place of abode) Pingree

If nonresident, give place and State

If nonresident, give place and State

Color or race White Age at last Birthday 35 (Years)

Color or race White Age at last Birthday 34 (Years)

Birthplace Idaho
(City and State or Country)

Birthplace Idaho
(City and State or Country)

Occupation Farmed

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 2:30 a M. on the date above stated.

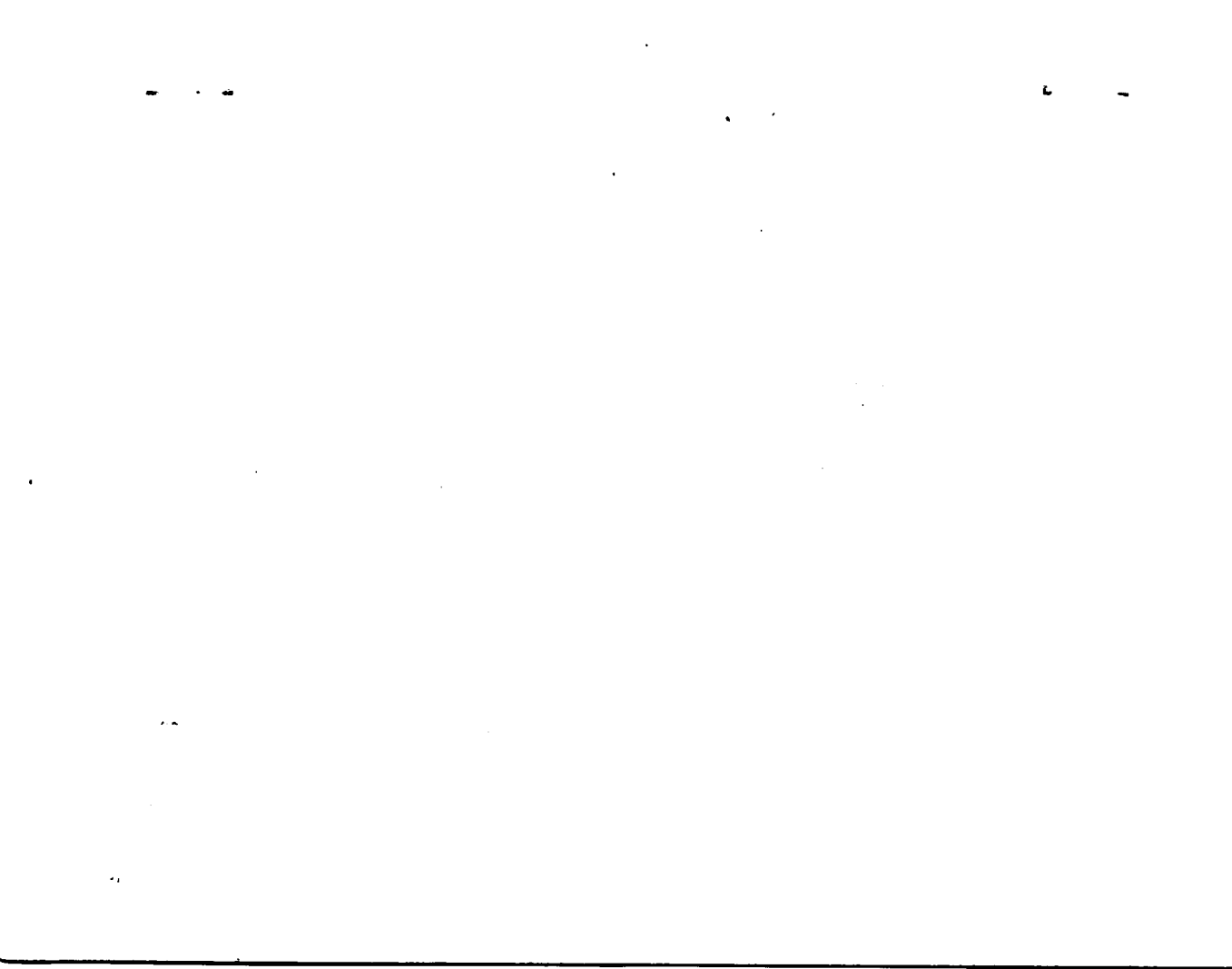
(Signature) W. Beck

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Blackfoot Idaho

Filed Dec 31 1928 Wm. Cleaveland Registrar.



RECEIVED JAN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 63974

PLACE OF DEATH

County of Bingham
City of PingreeRegistration District No. 121Primary Registration District No. 2144

(No. _____)

Local Registrar's No. 206

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn Thompson(a) Residence. No. Pingree, Idaho St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofDec 5, 19286 DATE OF BIRTH (month, day and year) Dec 57 AGE Stillborn Years Months DaysIf LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pingree, Idaho
(State or country)10 NAME OF FATHER Floyd C. Thompson11 BIRTHPLACE OF FATHER (city or town) Blackfoot
(State or country) Idaho12 MAIDEN NAME OF MOTHER Edith Latrisa Furniss13 BIRTHPLACE OF MOTHER (city or town) Agden
(State or country) Utah14 Informant Floyd C. Thompson
(Address) Pingree, Ida.15 Filed Dec 5, 1928 Wm. W. Baker Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Stillborn
Dec 5 1928
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
Had been dead several days

_____, 19_____, to _____, 19_____,

that I last saw h. _____ alive on _____, 19_____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Placental Infarct

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Mother had Influenza
(Secondary) about a week before

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted _____
If not at place of death? _____Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) W. W. Baker, M. D.12/5, 1928 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Presidents Thomas Date of Burial Dec 6 192820. Undertaken by Floyd C. Thompson Address Pingree Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth returned.

1455-2081006-813

PLACE OF RECEIVED

County of Bingham JAN 8 1928
City of Beckfoot
No. 42 St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

- CERTIFICATE OF BIRTH

166910

Registration District No. 121 State File No. 166910

Prim. Registration District No. 1007 Local Registrar's No. 472

FULL NAME OF CHILD

Betty June Dunnick

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>and</u> } and { Number in order of birth <u>1</u>	Legitimate? <u>Yes</u>	Date of birth <u>Dec 8</u> 19 <u>28</u> (Month) (Day) (Year)
----------------------------	---	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Charles Alfred Dunnick</u>	MOTHER FULL MAIDEN NAME <u>Grace Leilah Hall</u>
---	---

Residence (Usual place of abode) Beckfoot

If nonresident, give place and State

Color or race White Age at last Birthday 22 (Years)

Birthplace Kansas (City and State or Country)

Occupation Laborer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 11:30 a M. on the date above stated.

(Signature) W. Beck

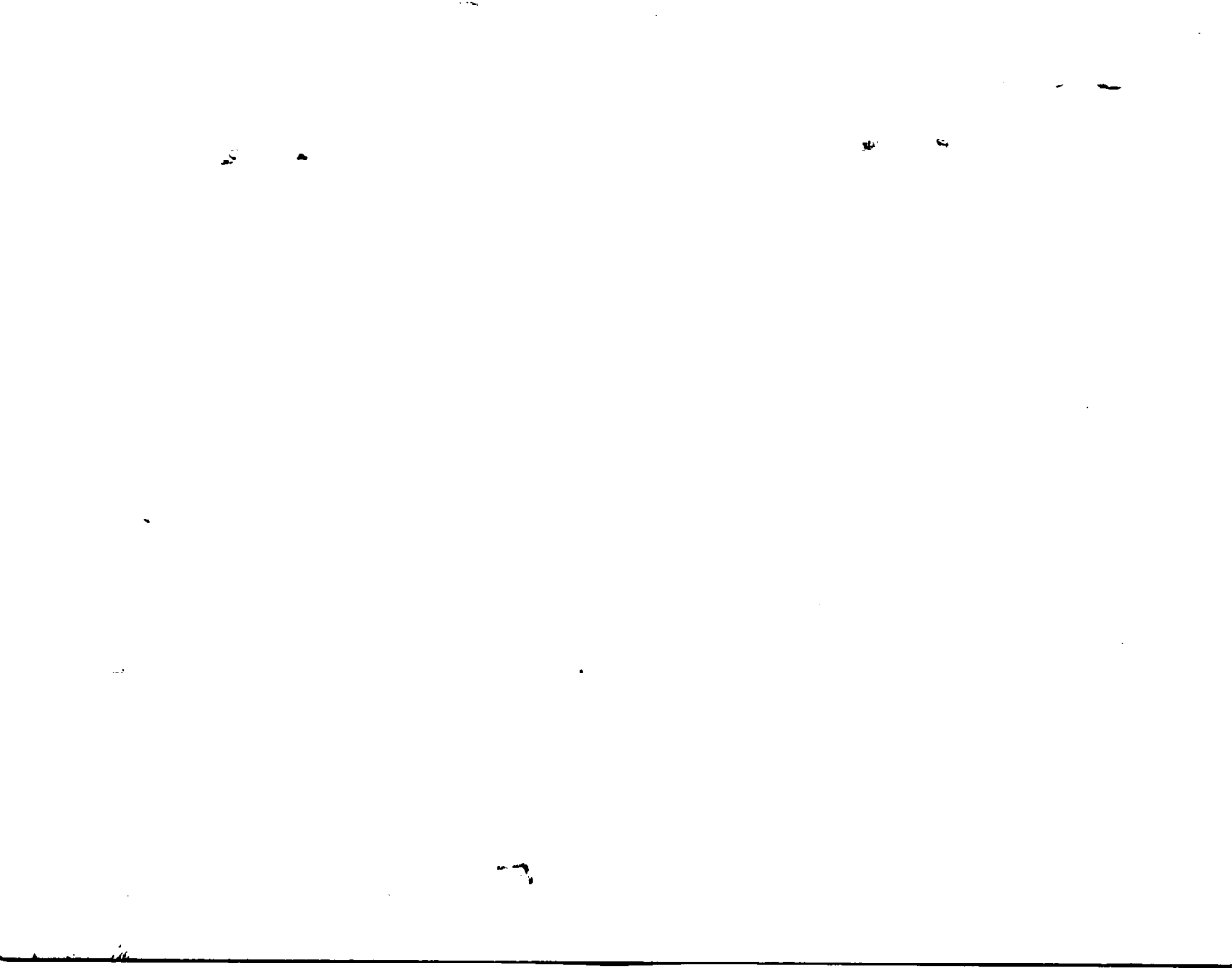
*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Beckfoot Supp

Filed Dec 31 1928 W. C. Calvert

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **63975**

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 107
(No. 716 Blackfoot)

Local Registrar's No. 207

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Betty June Dunnick(a) Residence. No. Blackfoot, Ida St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Dec 8, 1928

7 AGE Stillborn Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Blackfoot, Ida
(State or country)10 NAME OF FATHER Charles Alfred Dunnick11 BIRTHPLACE OF FATHER (city or town) Kansas
(State or country)12 MAIDEN NAME OF MOTHER Grace Leilah Hall13 BIRTHPLACE OF MOTHER (city or town) Utah
(State or country)

14 Informant Charles Alfred Dunnick
(Address) Blackfoot, Ida, H.D.

15 Filed Dec 8, 1928 H. McChesney Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 8 19 28
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 19 28, to Dec 8, 19 28, that I last saw him alive on Stillborn, 19 28, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Slow protracted labor

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) W. W. Beck M. D.
Dec 8, 19 28 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal G. C. Cem. Blackfoot, Ida Date of Burial Dec 10 1928
20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

335-224-006-651
PLACE OF BIRTH JAN 8 1909
County of Cinghian
City of Blackfoot
No. RD # 3 St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 166919

Registration District No. 121

State File No.

(If born in hospital or institution give name.)

Prim. Registration District No. 2194

Local Registrar's No. 481

FULL NAME OF CHILD

Stillbirth Clement

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child

Female

Twin
Triplet
or other?

and

Number
in order
of birth

(To be answered only in event of plural births)

Legiti-
mate?

Yes

Date of
birth

Dec 24

(Month) (Day)

19 28

(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth

9

(a) Born alive and now living

6

Born alive but now dead

3

Stillborn

1

FULL
NAME

FATHER
Clarence M. Clement

FULL
MAIDEN
NAME

MOTHER
Florence Weaver

Residence (Usual place of abode)

Blackfoot

Residence (Usual place of abode)

Blackfoot

If nonresident, give place and State

Idaho

If nonresident, give place and State

Idaho

Color or race

White

Age at last Birthday

40

Color or race

White

Age at last Birthday

39

Birthplace

Idaho

(City and State or Country)

Birthplace

Idaho

(City and State or Country)

Occupation

Farmer

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Stillborn } at 10:30 P M.
on the date above stated.

(Signature)

W W Beck

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or ~~midwife~~)

Address

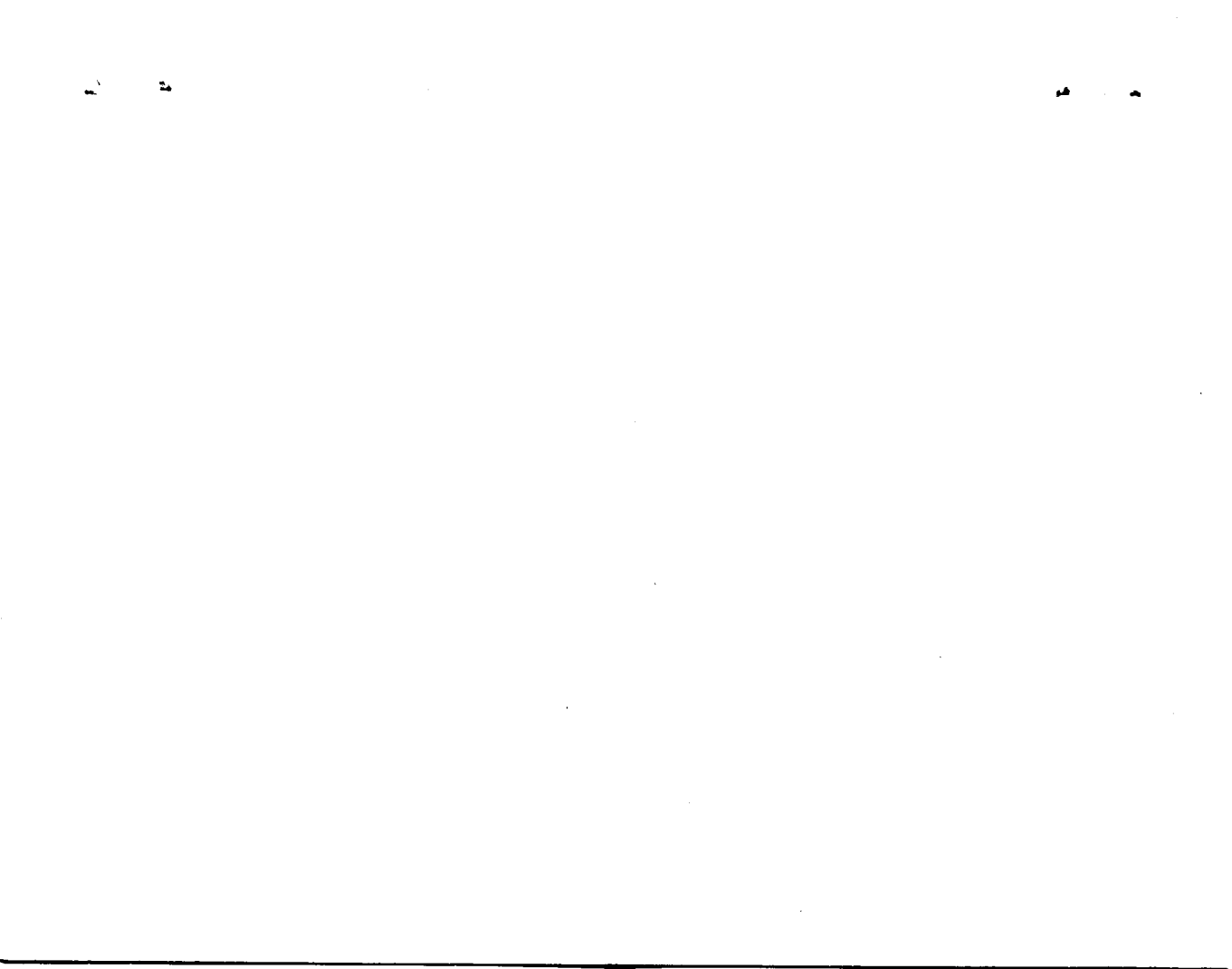
Blackfoot, Idaho

Filed

Dec. 31 1928

Mr. Walter E. Taber

Registrar.



RECEIVED JAN 8 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 63987

Local Registrar's No. 220

PLACE OF DEATH

County of Bingham
City of Blackfoot

CERTIFICATE OF DEATH

Registration District No. 121Primary Registration District No. 2194

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clement

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of _____

6 DATE OF BIRTH (month, day and year)

Dec 24, 1928

7 AGE

StillbornIf LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of workNone(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Blackfoot
Idaho

10 NAME OF FATHER

Clarence M. Clement11 BIRTHPLACE OF FATHER (city or town)
(State or country)Utah

12 MAIDEN NAME OF MOTHER

Florence Negro13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Idaho

PARENTS

14

Informant Clarence M. Clement
(Address) Blackfoot, Idaho 833

15

Filed Dec 26, 1928 M. C. Waters Idaho
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec
(Month)24
(Day)1928
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____.

that I last saw him alive on _____, 19____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Thrombosis of
umbilical vessels

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)Influenza with
severe cough (1 month)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) W. Beck M. D.Dec 26, 1928 (Address) Blackfoot*State the DISEASE CAUSING DEATH, or in deaths from VIO-
LENT CAUSES, state (1) MEANS AND NATURE OF INJURY,
and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal

Date of Burial

Mountain Idaho Dec 26, 1928

20. Undertaker

Address

C. M. Clement Blackfoot
#31WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC-
CUPATION is very important. See instructions on back of certificate.

MAKING RESERVED FOR BINDING

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS —Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

238-231-010-433
PLACE OF BIRTH
County of Bonneville JAN 3 1929
City of Idaho Falls
No. St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

166994

Registration District No. 72 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 70 Local Registrar's No. 619

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate <u>Yes</u>	Date of birth <u>Dec. 31</u> 19 <u>28</u> (Month) (Day) (Year)
----------------------------	---	---	----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead Stillborn 1

FATHER
FULL NAME Anton J Schwarzenberger
Residence (Usual place of abode) Idaho Falls, Ida
If nonresident, give place and State
Color or race White Age at last Birthday 34
Birthplace Wisconsin (Years)
(City and State or Country)
Occupation Farming

MOTHER
FULL MAIDEN NAME Ella May McCowin
Residence (Usual place of abode) Idaho Falls, Idaho
If nonresident, give place and State
Color or race White Age at last Birthday 33 34
Birthplace Wisconsin Utah (Years)
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive Stillborn } at 11.50 A. M.
on the date above stated.

(Signature) W. A. Hollister

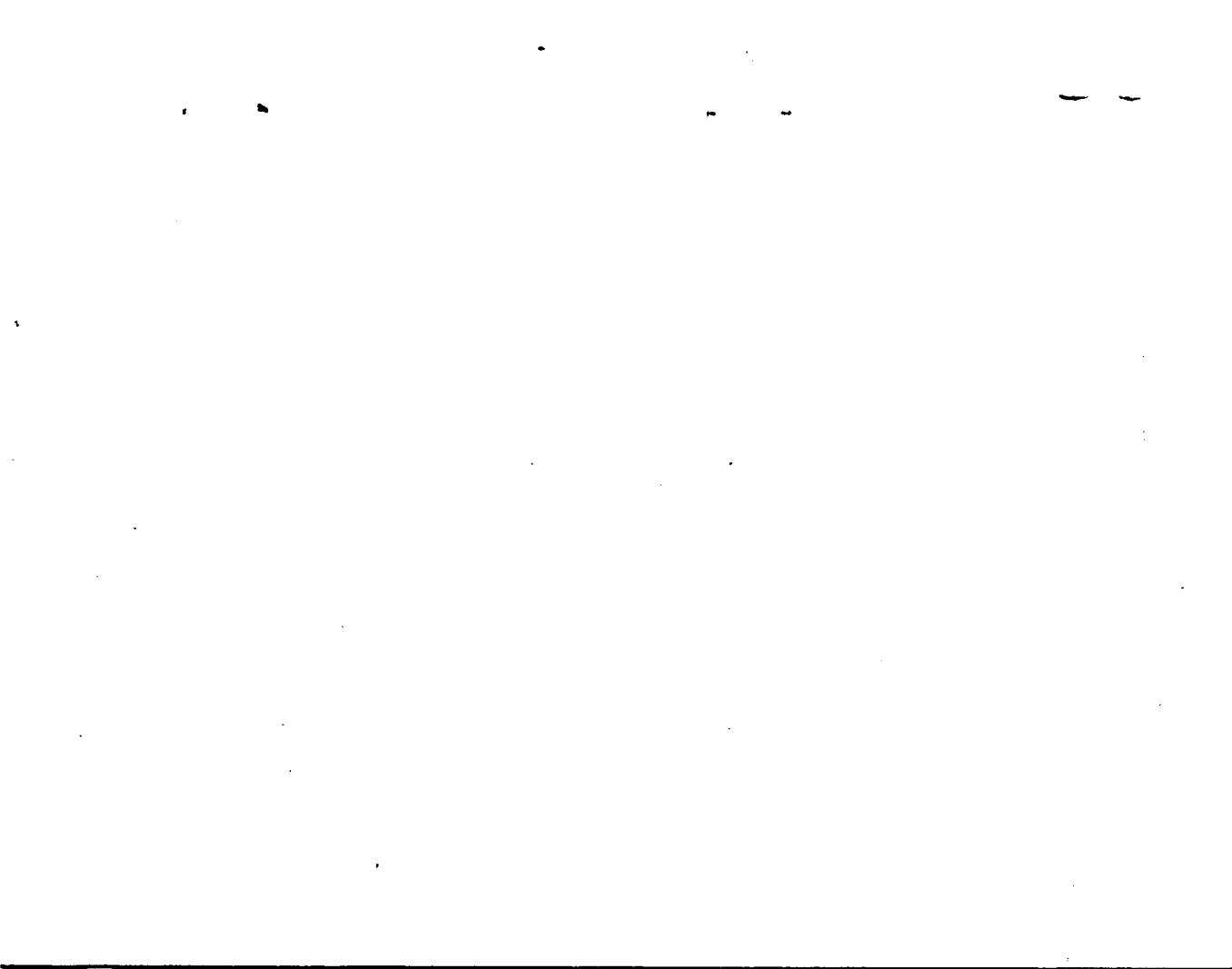
Physician

(Physician or midwife)

Address Idaho Falls, Idaho

Filed Dec 31 19 28 W. A. Hollister
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

64011

State File No.....

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150

Local Registrar's No. 221

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillbirth -

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word) -----
6a. If married, widowed, or divorced HUSBAND of (or) WIFE of		
6. DATE OF BIRTH (month, day and year) Dec. 31, 1928		
7. AGE Years 0	Months 0	Days 0 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work ----- (b) General nature of industry, business, or establishment in which employed (or employer) ----- (c) Name of employer		

9. BIRTHPLACE (city or town) Idaho Falls, Idaho
(State or country)

10. NAME OF FATHER Anton J. Schwarzenberger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Ellie May McCowin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant A. J. Schwarzenberger
(Address) Idaho Falls, Idaho - RFD #2

15. Filed Dec 31, 1928 W. J. Gorman
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
December 31, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
~~Idaho Falls~~, 19____, to Stillborn, 19____
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Stillbirth

(duration) yrs. mos. ds.
CONTRIBUTORY Not known
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? Dr. Hallister, M. D.
(Signed) Dec. 31/28, 19____ (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho	Date of Burial Jan 2 1929
20. Undertaker <u>Leon</u>	Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JAN 3 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
167027

468-119-010-49
County of Bonneville
City of Idaho Falls

No. St. Registration District No. 73 State File No.
Hospital Primary Registration District No. 2123 Local Registrar's No. 0-26

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child M. Twin Triplet or other? \ and { Number in order of birth \ Legitimate? yes Date of birth Aug 10 1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? yes

Number of child of this mother, including present birth 5 Number of child of this mother now living, including present birth 5

FATHER
FULL NAME Peter J Mahari
RESIDENCE Idaho Falls Ida
COLOR A AGE AT LAST BIRTHDAY 33
(Years)
BIRTHPLACE Greece
OCCUPATION Sheep man

MOTHER
FULL MAIDEN NAME Argenta Miles
RESIDENCE Idaho Falls Ida
COLOR A AGE AT LAST BIRTHDAY 32
(Years)
BIRTHPLACE Centralia Ill
OCCUPATION housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10 P. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.
....., 192.....

(Signature) Ed Rogers
Phys.
(Physician or midwife)

Address Idaho Falls Idaho
Filed Dec 1 1928 Ed Rogers

Registrar.

Registrar.

THE STATE OF TEXAS, COUNTY OF DALLAS, SS. I, the undersigned, a Justice of the Peace for said County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County.

Register.

1923

(Give names added from a supplemental report show other evidence of life after birth. child is one that neither practice nor etc., should make this return. A stillborn or stillwife, then the father, householder or wife, there was no attending physician on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

I hereby certify that I attended the birth of this child, who was born alive at 10:10 on the date above stated.

(Physician or midwife)

(Signature)

Address

Filed

1923

Registrar.

Address

(Physician or midwife)

(Signature)

I hereby certify that I attended the birth of this child, who was born alive at 10:10 on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE.

OCCUPATION Physician

BIRTHPLACE St. Louis, Mo.

COLOR White

AGE AT LAST BIRTHDAY 32 (Years)

RESIDENCE St. Louis, Mo.

FATHER FULL NAME John F. Smith

Number of child of this mother, including present birth 1

MOTHER FULL MAIDEN NAME John F. Smith

Number of child of this mother now living, including present birth 1

What bactericidal solution was used in case?

Sex of Child Male

Weight 7 lbs.

Length 20 in.

Birth 10:10

Time 10:10

Place of Birth St. Louis, Mo.

State of Texas

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

SEP 21 1928
PLACE OF DEATH

County of Bonneville
City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 23
Primary Registration District No. 2 IN 0

DO NOT WRITE IN THIS SPACE

State File No. 62994

Local Registrar's No. 21

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. Idaho Falls St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male 4. COLOR OR RACE White 5. Single Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 10, 1928

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 00 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls
(State or country)

10. NAME OF FATHER Peter J. Maheras

11. BIRTHPLACE OF FATHER (city or town) Greece
(State or Country)

12. MAIDEN NAME OF MOTHER Argenta Miles

13. BIRTHPLACE OF MOTHER (city or town) Nebraska
(State or Country)

14. Informant Peter J. Maheras
(Address) Idaho Falls Idaho

15. Filed Aug 13, 19 28 Deft. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 10 28
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19____, to 19____,
that I last saw h. alive on 19____,
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:

Shelton

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
(Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of ____

Was there an autopsy? ____

What test confirmed diagnosis?

(Signed) Dr. Roger A. M.D.

19____ (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rose Hill Cemetery Date of Burial Aug. 12 1928

20. Undertaker T. F. M. Hou Address Idaho Falls

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

556-2169-169
PLACE OF BIRTH JAN 4 1929

County of Elmore
City of Elmer's Ferry
No. St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 167118

Registration District No. 35 State File No.

(If born in hospital or institution
give name.)

Prim. Registration District No. 2021 Local Registrar's No.

FULL NAME OF CHILD Unnamed

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? <u>1</u>	and {	Number in order of birth <u>2</u>	Legiti- mate? <u>yes</u>	Date of birth <u>Dec. 16</u>	<u>1928</u>
	(To be answered only in event of plural births)				(Month) (Day) (Year)	

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 3 (a) Born alive and now living 1

Born alive but now dead None Stillborn 1

FATHER
FULL NAME Leon C. Newell
Residence (Usual place of abode) Elmer's Ferry Idaho
If nonresident, give place and State
Color or race white Age at last Birthday 39
Birthplace Oregon
(City and State or Country)
Occupation Mechanic

MOTHER
FULL MAIDEN NAME Grace Jordan
Residence (Usual place of abode) Elmer's Ferry
If nonresident, give place and State
Color or race white Age at last Birthday 24
Birthplace Oregon
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 3:35 P. M.
on the date above stated.

(Signature) J. W. Davis
Physician
(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Elmer's Ferry Idaho
Filed Dec. 17 1928 J. W. Davis
Registrar.

100V

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JAN 7 1929

PLACE OF BIRTH
County of Franklin
City of Preston
No. 695-219-021-648 St.
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S167127**

Registration District No. 27 State File No. _____
Prim. Registration District No. 2119 Local Registrar's No. 308

FULL NAME OF CHILD _____
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? _____ (To be answered only in event of plural births)	and { Number in order of birth _____	Legitimate? <u>Yes</u>	Date of birth <u>Dec. 19, 1928</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 3 (a) Born alive and now living 2
Born alive but now dead _____ Stillborn 1

FATHER	MOTHER
FULL NAME <u>J. Clifford Prosgren</u>	FULL MAIDEN NAME <u>Mary Onetta Fuhrman</u>
Residence (Usual place of abode) <u>Preston, Idaho</u>	Residence (Usual place of abode) <u>Preston, Ida.</u>
If nonresident, give place and State _____	If nonresident, give place and State _____
Color or race <u>White</u> Age at last Birthday <u>35</u>	Color or race <u>White</u> Age at last Birthday <u>31</u>
Birthplace <u>Idaho</u> (Years) _____	Birthplace <u>Utah</u> (Years) _____
Occupation <u>Co. Supt. of Public Schools</u> (City and State or Country)	Occupation <u>Housewife</u> (City and State or Country)

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

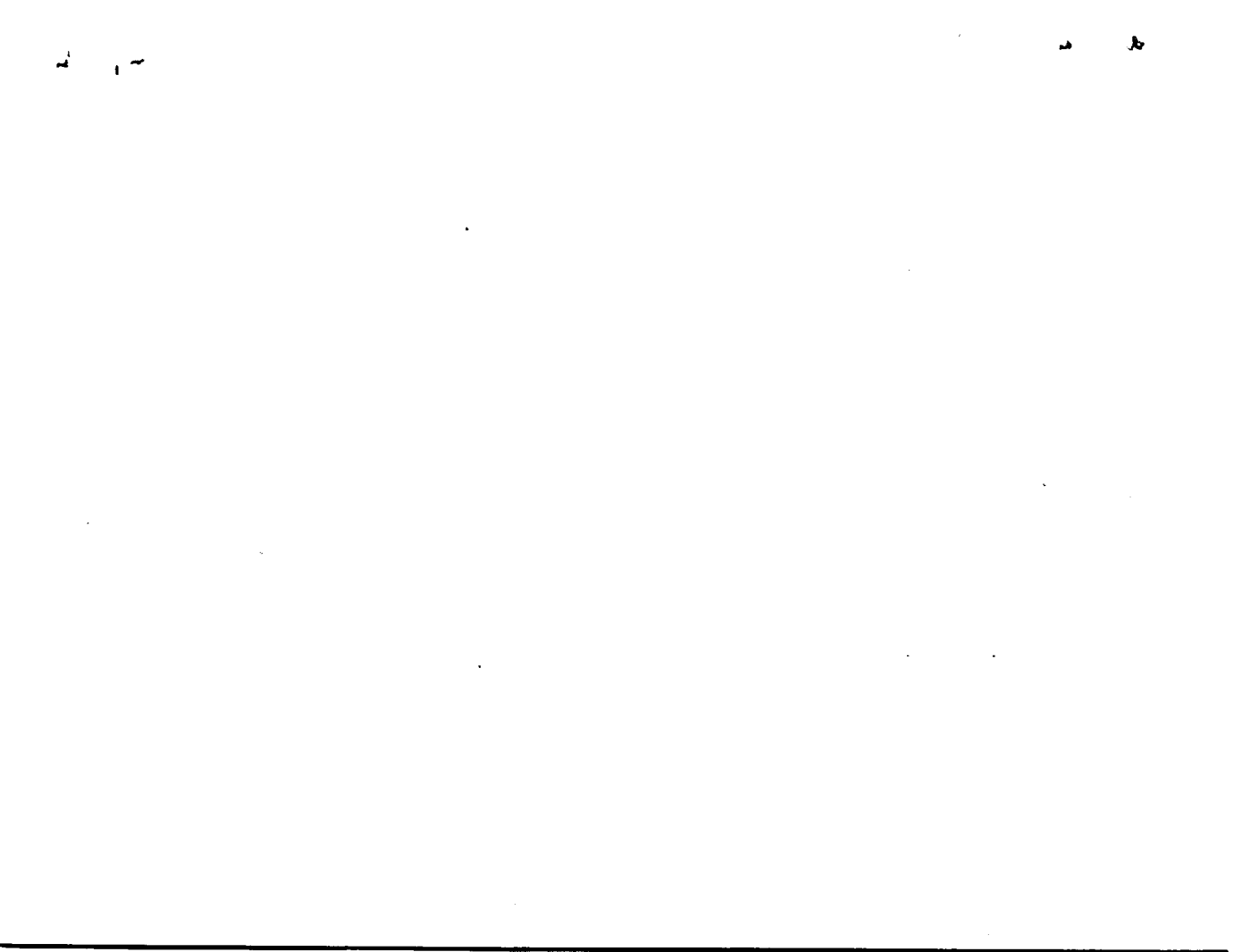
I hereby certify that I attended the birth of this child, who was Born alive at 2:15 A. M. on the date above stated.

(Signature) A. P. Cutler
Physician
(Physician or midwife)

Address Preston, Idaho

Filed Jan. 2, 1929 A. P. Cutler
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 7 1929

PLACE OF DEATH

County of FranklinCity of PrestonSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 27Primary Registration District No. 2119

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Frosgren

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed, or Divorced (write the word) <u>Single</u>
-------------------------	----------------------------------	---

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u> min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work None(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Preston, Idaho
(State or country)

10. NAME OF FATHER

J. Clifford Frosgren11. BIRTHPLACE OF FATHER (city or town)
(State or Country)Idaho

12. MAIDEN NAME OF MOTHER

Mary Oretta Fuhrman13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)Utah14. Informant J. Clifford Frosgren(Address) Preston, Idaho15. Filed Jan. 3, 1929Registrar A. R. Butler

DO NOT WRITE IN THIS SPACE

State File No. 64093Local Registrar's No. 56

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 19, 1928

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 19, 1928, to Dec. 19, 1928

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Still born.
Probably due to influenza
mother typed 3 weeks prior to
birth (duration) _____ yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) A. R. Butler M. D.Dec. 20, 1928 (Address) Preston, Idaho*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Preston. 19____

20. Undertaker

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

883-304-924-312
 PLACE OF BIRTH
 County of Gooding
 City of Hagerman
 No. _____ St. _____
 Registration District No. 21

STATE OF IDAHO
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

Form V. S. No. 11-25m-6-15-18

File No. 167172

Hospital _____
 Primary Registration District No. _____ Registered No. _____

Full Name of Child Genevieve M. Hylton

SEX OF CHILD Female Twin ☒ Triplet ☐ or other? ☐ {and} Number in order of birth _____ Legitimate? Yes DATE OF BIRTH Aug 4 1927
 (To be answered only in event of plural births) (Month) (Day) (Year)

FULL NAME Louis Hylton FATHER
 RESIDENCE Hagerman
 COLOR White AGE AT LAST BIRTHDAY 27 (Years)
 BIRTHPLACE Calif
 OCCUPATION Farmer

FULL MAIDEN NAME Alice Casto MOTHER
 RESIDENCE Hagerman
 COLOR White AGE AT LAST BIRTHDAY 25 (Years)
 BIRTHPLACE Idaho
 OCCUPATION Housewife

Number of child of this mother, including present birth 4 Number of children of this mother now living, including present birth 2

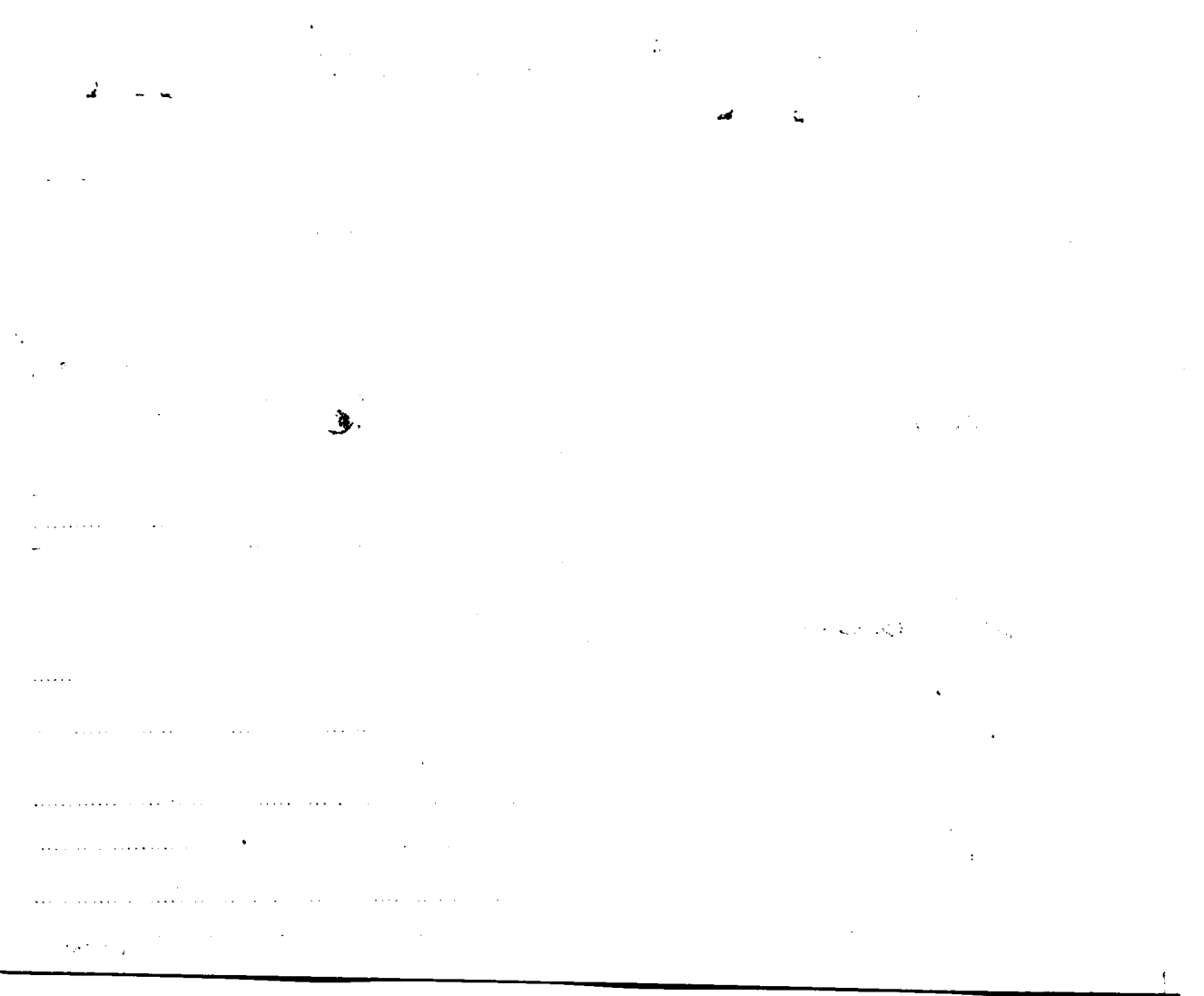
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 9 P M.
 on the date above stated. (Born alive or stillborn)

{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth. }

(Signature) R H Greene
Physician
 (Physician or midwife)

Given names added from a supplemental report _____
 Address _____
 Filed Sept 1 1927 Registrar R H Greene



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

JAN 5

1929

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Hagerman

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No. _____

(No. _____ St.)

File No. 64114

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Gene Louise Hylton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Infant
(Write the word.)

6. DATE OF BIRTH

Still Born
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs.
or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Hagerman

10. NAME OF FATHER

Louis Hylton

11. BIRTHPLACE OF FATHER

(State or Country)

Calif

12. MAIDEN NAME OF MOTHER

Alice Casto

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gene Hylton

(Address)

Hagerman

15.

Filed

Aug 30 1928

R H Greene

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 28 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth 19 28

that I last saw him on Aug 28 1928

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

R H Greene M. D.

19. (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hagerman Aug 28 1928

20. UNDERTAKER

ADDRESS

None

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

238-120-224-243
 PLACE OF BIRTH RECEIVED JAN 5 1929

STATE OF IDAHO
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

Form V. S. No. 11-25m-6-15-18

County of Gooding
 City of Hagerman
 No. _____ St. _____

Registration District No. 2

File No.

167176

Hospital _____

Primary Registration District No. _____

Registered No. _____

Full Name of Child

Lee Rolland Schulz

SEX OF CHILD male Twin Triplet or other? _____ {and} Number in order of birth _____ Legitimate? yes DATE OF BIRTH July 20 1928
 (To be answered only in event of plural births) (Month) (Day) (Year)

FATHER		MOTHER	
FULL NAME	<u>H. T. Schulz</u>	FULL MAIDEN NAME	<u>Nora Jane Butts</u>
RESIDENCE	<u>Bliss</u>	RESIDENCE	<u>Bliss</u>
COLOR	<u>White</u>	COLOR	<u>White</u>
AGE AT LAST BIRTHDAY	<u>27</u> (Years)	AGE AT LAST BIRTHDAY	<u>24</u> (Years)
BIRTHPLACE	<u>N. Y.</u>	BIRTHPLACE	<u>Kansas</u>
OCCUPATION	<u>Farmer</u>	OCCUPATION	<u>Housewife</u>

Number of child of this mother, including present birth 2 Number of children of this mother now living, including present birth 1

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Still born at 4:30 P. M. on the date above stated. (Born alive or stillborn)

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Premature born when I arrived.
 (Signature) R. H. Greene

Physician
 (Physician or midwife)

Given names added from a supplemental report

Address

Filed

July 23 1928

Hagerman
R. H. Greene

Registrar

Registrar

N. B.—In case of more than one child at birth, a 2nd, 3rd, etc., of each, in order of birth.

JAN 19 1950

1950 1 1950

no D

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

433-1153 825-863

PLACE OF BIRTH

RECEIVED

JAN 9 1929

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

167210

County of Idaho

City of Brangerville

No. _____ St. Registration District No. 103 State File No. _____

Hospital _____ Primary Registration District No. 1001 Local Registrar's No. 176

FULL NAME OF CHILD Stillbirth

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>12-3-28</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------------	-----------------------------	---

What bactericidal solution was used in eyes? _____

Number of child of this mother, including present birth 1 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Earl Mc Connell
RESIDENCE Brangerville Ida
COLOR White AGE AT LAST BIRTHDAY 30
(Years)
BIRTHPLACE Flournoy Ida.
OCCUPATION Forest Ranger

MOTHER
FULL MAIDEN NAME Dorothy Holmes
RESIDENCE Brangerville Ida
COLOR White AGE AT LAST BIRTHDAY 28
(Years)
BIRTHPLACE Helena. Mond.
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at 3 P. M. on the date above stated.

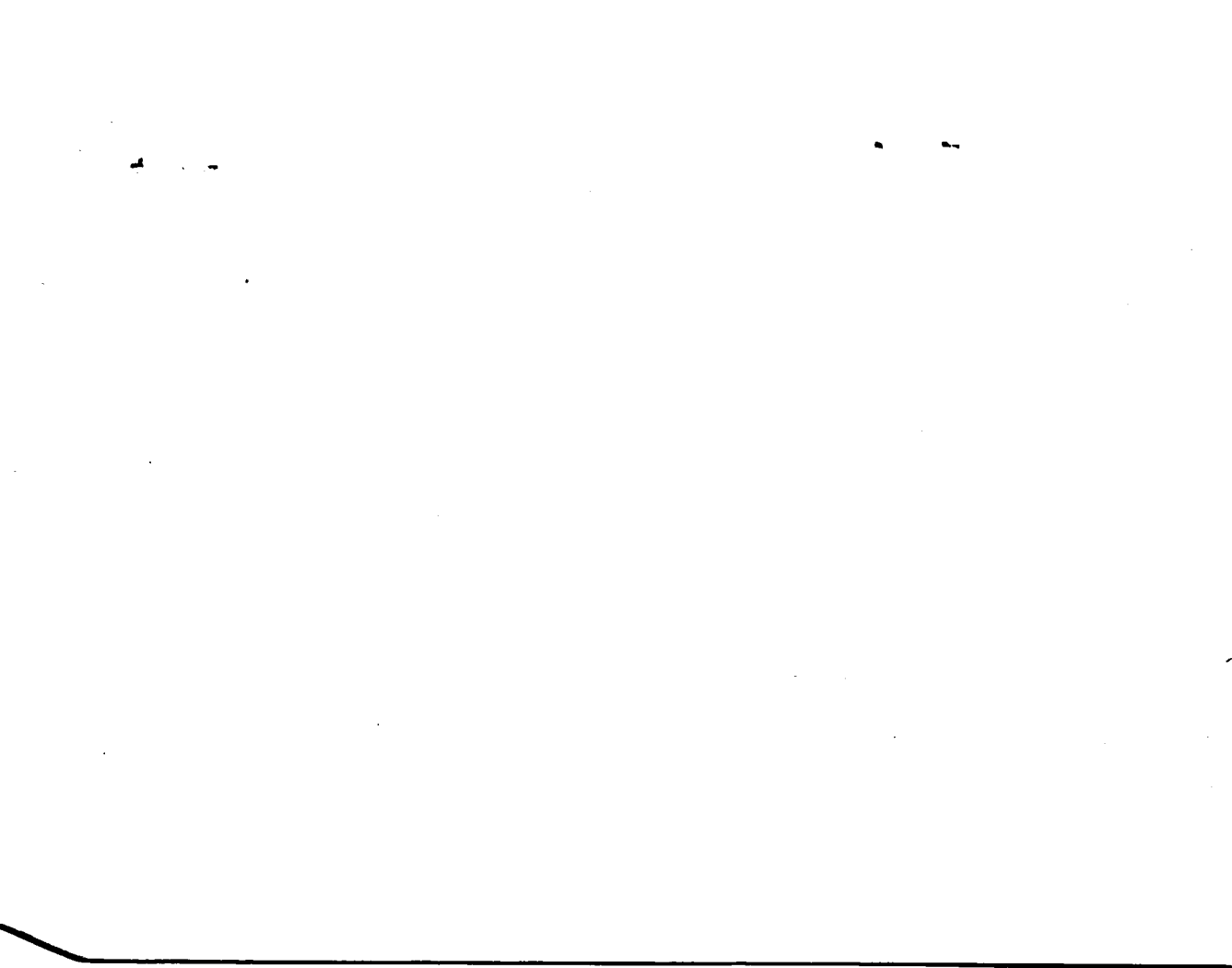
*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) B. Chipman
Physician
(Physician or midwife)

Address Brangerville, Ida.

Filed 1-7- 1929 B. Chipman
Registrar.



RECEIVED JAN 9 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. **64121**

PLACE OF DEATH

County of Idaho
City of GrangevilleCERTIFICATE OF DEATH
Registration District No. 103
Primary Registration District No. 1001
(No. _____)Local Registrar's No. 96

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillbirth

(a) Residence. No. _____ St.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____6 DATE OF BIRTH (month, day and year) Dec 3-1928

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Grangeville
(State or country) Idaho10 NAME OF FATHER Earl McCormell11 BIRTHPLACE OF FATHER (city or town) Florence
(State or country) Idaho12 MAIDEN NAME OF MOTHER Dorothy Holmes13 BIRTHPLACE OF MOTHER (city or town) Helena Mont.
(State or country)14 Informant Mrs Dorothy McCormell
(Address) Grangeville Ida.15 Filed 1-7-, 1929 B. Chipman
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 3- 1928
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Placental Separation of
light months
(duration) _____ yrs. _____ mos. _____ ds.CONTRIBUTORY Not known
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) B. Chipman M. D.
Dec 10, 1928 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Grangeville Ida Date of Burial 12-4 192820. Undertaker C. A. Harrock Address GrangevilleWRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

132-213-028-993

PLACE OF BIRTH

County of Kootenai
City of Spokane Lake

No. 1 St. 1

Spokane Lake 9th
(If born in hospital or institution
give name.)

Registration District No. 45 State File No. 167345

Prim. Registration District No. 16 Local Registrar's No. 16

FULL NAME OF CHILD Steelbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>F</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>7</u> <u>13</u> <u>1928</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 1 (a) Born alive and now living no

Born alive but now dead no Stillborn yes

FATHER
FULL NAME Harold Atkinson

Residence (Usual place of abode) Spokane Lake

If nonresident, give place and State

Color or race white Age at last Birthday 27
(Years)

Birthplace London Ontario
(City and State or Country)

Occupation Book keeper

MOTHER
FULL MAIDEN NAME Frances Richardson

Residence (Usual place of abode) Spokane Lake Id

If nonresident, give place and State

Color or race white Age at last Birthday 25
(Years)

Birthplace Spokane Mich
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at Spokane Lake M.
on the date above stated.

(Signature) W. B. Lewis M.D.

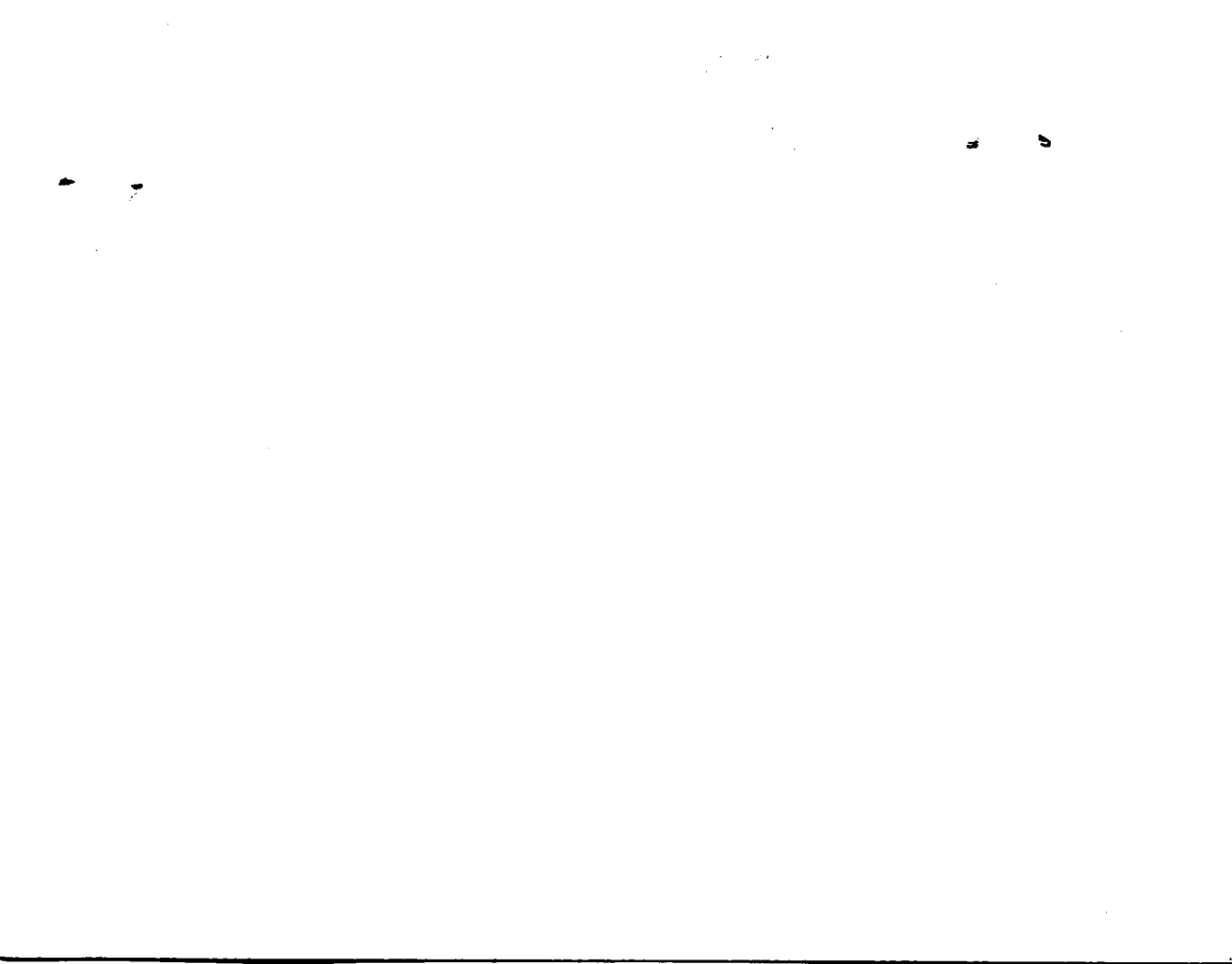
Phys.
(Physician or midwife)

Address Spokane Wash

Filed July 5 - 1928 W. B. Lewis

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 19 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

64171

State File No.

PLACE OF DEATH

County of Kootenai
City of Spirit Lake

Registration District No. 43

Primary Registration District No.

Local Registrar's No. 9

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7. 4. COLOR OR RACE W. 5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1928-7-13

7. AGE Years Months Days If LESS than 1 day,
7 0 0 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Spirit Lake
(State or country) Idaho

10. NAME OF FATHER Harold Atkinsen

11. BIRTHPLACE OF FATHER (city or town) London
(State or Country) Ontario

12. MAIDEN NAME OF MOTHER Frances Richardson

13. BIRTHPLACE OF MOTHER (city or town) Stouffville
(State or Country) Mich.

14. Informant
(Address)

15. Filed July 17, 1928 A. B. Spooner
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 13 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from

, 19, to , 19,

that I last saw him alive on , 19,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn

(duration) yrs. mos. ds.
CONTRIBUTORY Protracted - difficult
(Secondary) labor (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Lewis, M. D.7/17, 1928 (Address) Spirit Lake W. I.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Evergreen Cem. Spirit Lake 7-15 1928

20. Undertaker Address

Cassidy Funeral Home Spirit Lake

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

913123 028 219

PLACE OF BIRTH

County of Spokane

City of Spokane Lake

No. _____ St. _____

Spokane Lake Hosp. Registration District No. _____ State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. _____ Local Registrar's No. 18

FULL NAME OF CHILD Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>M</u>	Twin Triplet or other? (To be answered only in event of plural births)	and {	Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>7 23 1928</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum? no

Number of child of this mother, including present birth _____ (a) Born alive and now living _____

Born alive but now dead _____ Stillborn ✓

FATHER FULL NAME <u>Earl Bruce Zackery</u>	MOTHER FULL MAIDEN NAME <u>Hazel Bardwell</u>
---	--

Residence (Usual place of abode) Spokane Lake, ID

If nonresident, give place and State _____

Color or race white Age at last Birthday 22

Birthplace KalisPELL, MODANA (City and State or Country)

Occupation Logger

Residence (Usual place of abode) Spokane Lake, ID

If nonresident, give place and State _____

Color or race white Age at last Birthday 21

Birthplace CANADA (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 8:55 P. M.
on the date above stated.

(Signature) Nelson L. Hersey

(Physician or midwife)

Address Spokane Lake, Idaho

Filed July 25 1928 AC Spooner

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

1

2

3

4

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC-19 DEC 1 9 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64173

PLACE OF DEATH
County of Boonville
City of Spirit Lake

Registration District No. 45
Primary Registration District No. _____
(No. _____)

Local Registrar's No. 11

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carl Junion Jackary
(a) Residence. No. _____ St. _____
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Male 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Spirit Lake
(State or country)

PARENTS

10. NAME OF FATHER Carl. Jackary

11. BIRTHPLACE OF FATHER (city or town) Montana
(State or Country)

12. MAIDEN NAME OF MOTHER Hazel Bordwell

13. BIRTHPLACE OF MOTHER (city or town) Canada
(State or Country)

14. Informant Carl. Jackary
(Address) Spirit Lake

15. Filed 7-24, 1928 W. C. Spooner
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 23 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Stillborn 19____, to____, 19____
that I last saw h_____ alive on____, 19____
and that death occurred, on the date stated above, at____m.
The CAUSE OF DEATH* was as follows:

Stillborn

CONTRIBUTORY Protracted Labor (duration) ____ yrs. ____ mos. ____ ds.
atolecetasis (Secondary) (duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) W. C. Spooner M. D.
7-24, 1928 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Evergreen Cemetery Date of Burial 7/24 1928

20. Undertaker Cassedy Funeral Home Address Patheum
Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED JAN 5 1929
County of Franklin STATE OF IDAHO
City of Cubana, Idaho DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
No. 7592028-343 St. _____
(If born in hospital or institution
give name.) Registration District No. 20 State File No. 167351
Prim. Registration District No. 1051 Local Registrar's No. 213
FULL NAME OF CHILD Stillbirth - Bernard
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>December 2</u> (Month) (Day) (Year) <u>1928</u>
----------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth two (a) Born alive and now living two
Born alive but now dead one Stillborn one

FATHER	MOTHER
FULL NAME <u>William H. Bernard</u>	FULL MAIDEN NAME <u>Goldie Luther</u>
Residence (Usual place of abode) <u>122 Wallace, Cubana, Idaho</u>	Residence (Usual place of abode) <u>122 Wallace</u>
If nonresident, give place and State. _____	If nonresident, give place and State. _____
Color or race <u>W</u> Age at last Birthday <u>51</u> (Years)	Color or race <u>W</u> Age at last Birthday <u>42</u> (Years)
Birthplace <u>Iowa</u> (City and State or Country)	Birthplace <u>Iowa</u> (City and State or Country)
Occupation _____	Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 2:30 P. M.
on the date above stated.

(Signature) Harold T. Anderson

(Physician or midwife)

Address _____

Filed 12-10 1928 S. D. Roman

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-11-2009 BY 60322 UCBAW

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

I hereby certify that I attended the birth of this child, who was born on the date above stated.

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

Filed _____
Address _____
(Physician or midwife)
(Signature) _____
I attended the birth of this child, who was born on the date above stated.

Residence (City and State or County) _____
Color of race _____
It was born at _____
Residence (usual place of abode) _____
NAME (Last, first, and middle) _____
FATHER _____
MOTHER _____
Stillborn _____

Number of child of this mother, including present birth _____
What prophylactic was used to prevent Ophthalmia neonatorum _____
Sex of child _____
Child _____
To be answered only in event of birth _____
Date of birth _____
Lasted _____
Date of _____
Register the word "Stillborn" (if applicable)

Full name of child _____
If born in hospital or institution _____
Registration _____
Local Registration _____
State File No. _____
Certificate of Birth _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 5 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 64153

PLACE OF DEATH

CERTIFICATE OF DEATH

Local Registrar's No. 172

County of Booleman Registration District No. 30

City of New Adams Primary Registration District No. 1051

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME

(a) Residence. No. 102 Wallace ave St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day and year) Dec 2 - 1928

7 AGE Years Months Days If LESS than 1 day 0 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho

10 NAME OF FATHER William H Bernard

11 BIRTHPLACE OF FATHER (city or town) Douglas
(State or country)

12 MAIDEN NAME OF MOTHER Goldie Luther

13 BIRTHPLACE OF MOTHER (city or town) Douglas
(State or country)

14 Informant W H Bernard
(Address) Coeur d'Alene, Id.

15 Filled 12 - 4, 1928 W H Bernard
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 2 1928
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

that I last saw h_____ alive on _____, 19____.

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Stillborn (1 1/2 months)
Probably pre-eclampsic toxemia
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Harold T. Anderson M. D.
Dec. 3, 1928 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Forest Cemetery Date of Burial Dec 4 1928

20 Undertaker R B. Mooney Address Coeur d'Alene

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; after keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical state-

term for the same disease. Examples: Cerebro-spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

ment of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

285 203 038 436

PLACE OF BIRTH

County of Payette.

City of RECEIVED DEC 31 1928

No. St.

(If born in hospital or institution
give name.)

Registration District No. 4 State File No. 167485

Prim. Registration District No. 1008 Local Registrar's No. 72

FULL NAME OF CHILD Stillborn Infant of Myrtle Sherwood

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child	Female	Twin Triplet or other? (To be answered only in event of plural births)	{ and }	Number in order of birth	Legiti- mate?	Date of birth	Dec. 3, 1928		
							(Month)	(Day)	(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 5 (a) Born alive and now living 4
Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Rudolph Sherwood

Residence (Usual place of abode) Payette, Idaho

If nonresident, give place and State -----

Color or race White Age at last Birthday 43 (Years)

Birthplace Washington
(City and State or Country)

Occupation Beef Buyer

MOTHER
FULL MAIDEN NAME Myrtle McFarland

Residence (Usual place of abode) Payette, Idaho

If nonresident, give place and State -----

Color or race White Age at last Birthday 33 (Years)

Birthplace Missouri
(City and State or Country)

Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE* born dead

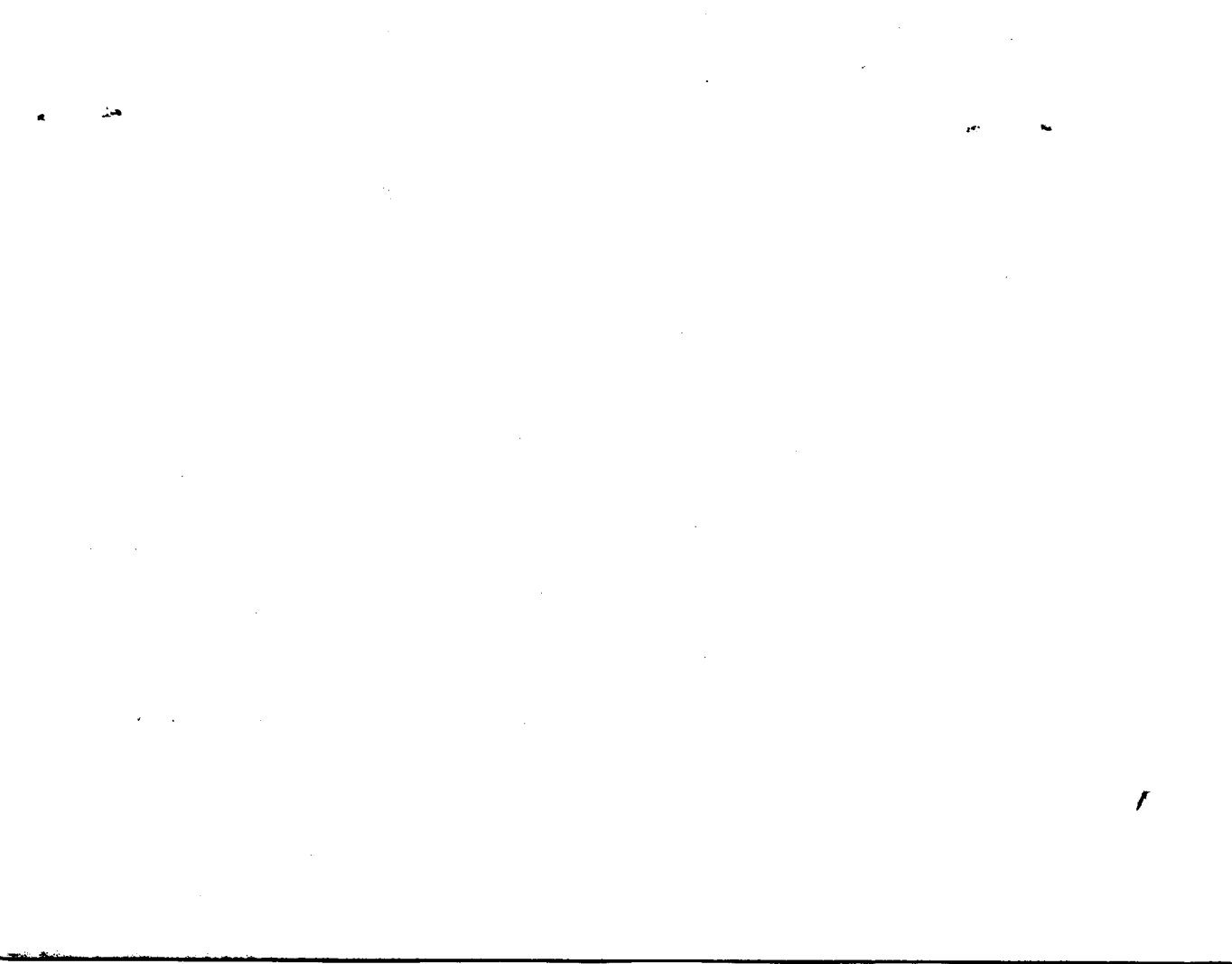
I hereby certify that I attended the birth of this child, who was Born alive 6:00 a.m.
on the date above stated. Stillborn

(Signature) J. C. Woodward
Physician
(Physician or midwife)

Address Payette, Idaho

Filed 1928 19 25 J. C. Woodward
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 31 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **64238**

PLACE OF DEATH

County of **PAYETTE**

City of _____

Registration District No. **4**

Primary Registration District No. **1008**

Local Registrar's No. **29**

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Stillborn Infant of Myrtle Sherwood.**

(a) Residence. No. **Payette Heights.** St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. Single, Married, Widowed, or Divorced (write the word) Infant
-------------------------	----------------------------------	--

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) **Dec. 3, 1928.**

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
-----	-----	-----	-----	-----

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **Payette**
(State or country) **Idaho.**

10. NAME OF FATHER **Rudolph Sherwood**

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER **Myrthe McFarland**

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant **H. J. Howard**
(Address) **Payette, Idaho**

15. Filed **Dec. 3**, 19 **28**

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 3, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
12/3/28, 19____, to **12/3/28**, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at **6.00** m.

The CAUSE OF DEATH* was as follows:

Stillborn.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) **J. C. Howard**, M. D.
12/3/28, 19____ (Address) **Payette, Idaho**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Payette, Idaho	Date of Burial 12/4/28 19____
---	---

20. Undertaker W. J. White	Address Payette, Id.
--------------------------------------	--------------------------------

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

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Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

County of _____

RECEIVED

JAN 4 1929

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

City of _____

CERTIFICATE OF BIRTH

S 167551

No. _____ St. _____

213-216 042-495

Registration District No. _____ State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 2687 Local Registrar's No. _____

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

Female

Twin
Triplet
or other? 1

and

Number
in order
of birth
1stLegiti-
mate?

Yes

Date of
birth16 Dec - 1925
(Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 1 (a) Born alive and now living

Born alive but now dead Stillborn

FATHER
FULL NAME Mrs H. Salaman

Residence (Usual place of abode) Buhl, Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 21 (Years)

Birthplace London, Eng (City and State or Country)

Occupation none

MOTHER
FULL MAIDEN NAME Hazel Minard

Residence (Usual place of abode) Buhl, Idaho

If nonresident, give place and State

Color or race White Age at last Birthday 18 (Years)

Birthplace Hagerman, Idaho (City and State or Country)

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 3 P.M.
on the date above stated. { Stillborn }

(Signature) J. W. McManus

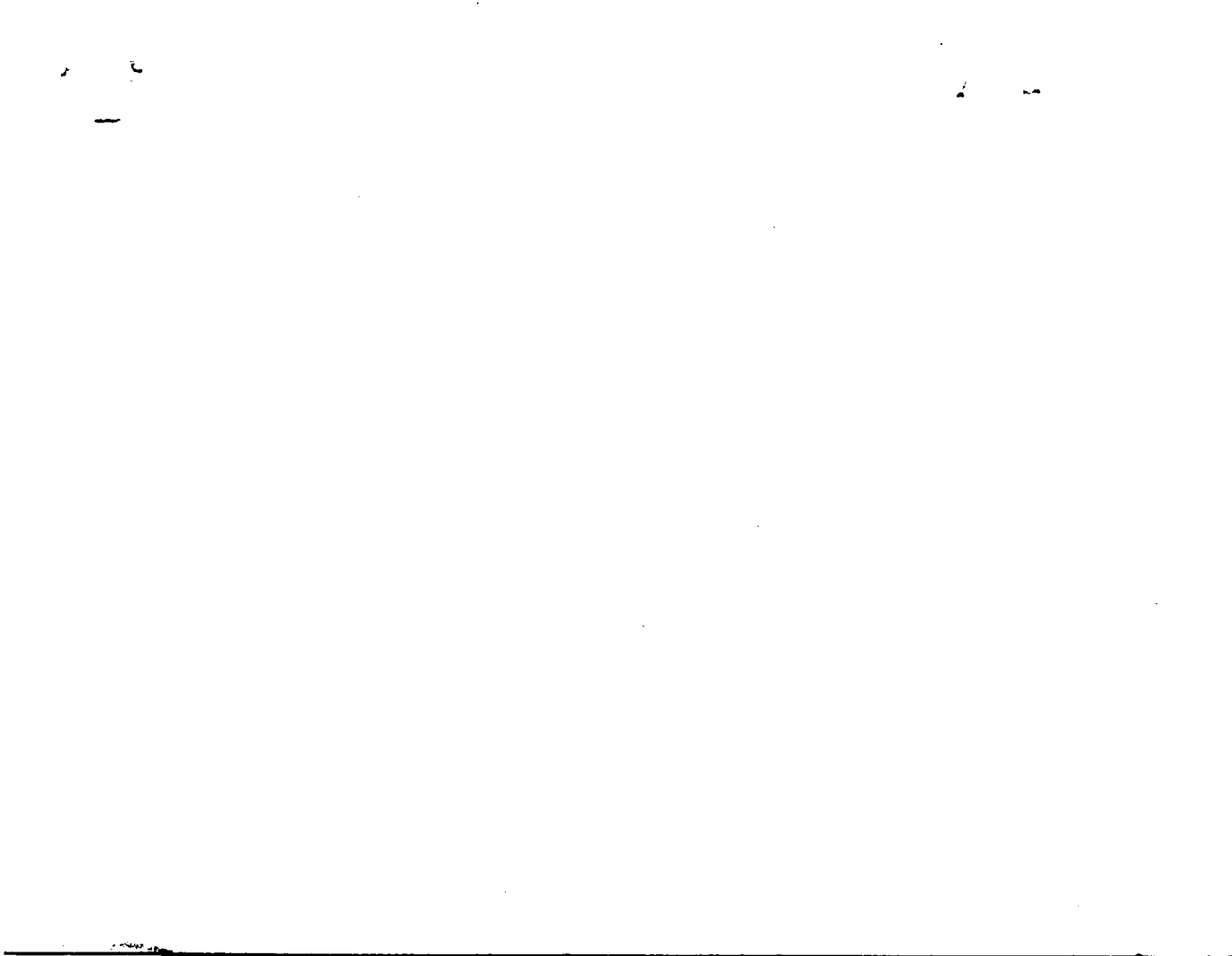
(Physician or midwife)

Address Buhl, Idaho

Filed 12-17 1928 J. H. Wierfling

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



RECEIVED JAN 4 1929

FORM V. S. No. 54

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Lucas Falls*
City of *Buho*

Registration District No.

Primary Registration District No.

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Baby Solomon*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **64270**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Female White Single*
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

IF LESS than 1 day

how many hrs.

or min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business or establishment in which employed (or employer)

at Home

9. BIRTHPLACE

(State or Country)

Buho Ida

10. NAME OF FATHER

William H. Solomon

11. BIRTHPLACE OF FATHER

(State or Country)

London England

12. MAIDEN NAME OF MOTHER

Rachel Alma Minard

13. BIRTHPLACE OF MOTHER

(State or Country)

Hagerman

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Solomon

(Address)

Buho

15.

Filed *12-16-1928*

Local Registrar

16. DATE OF DEATH

12-16-28
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at birth, to 19.....

that I last saw him alive on 19.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. W. Mac Magnus* M. D.19..... (Address) *Buho, Idaho*

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hagerman Ida.

DATE OF BURIAL

12/16/28

20. UNDERTAKER

L. Johnson

ADDRESS

Buho Ida

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc.. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

N. B. In case of more than one child at birth, a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

316 13 / 0444 - 293

PLACE OF BIRTH

STATE OF IDAHO
BUREAU OF VITAL STATISTICS

Form V. S. No. 11-C-25m-9-8-15

County of

Washington

RECEIVED

JAN 5 1929

CERTIFICATE OF BIRTH

City of

Cambridge

Registration District No.

File No.

S 167568

No. St.

Primary Registration District No.

Registered No.

Hospital

FULL NAME OF CHILD

Infant Richardson Lawrence.

Sex of Child

Male

Twin
Triplet
or other?

Triplet

and

Number
in order
of birth

3

Legiti-
mate?

Yes

Date of
Birth

5-31-28

(Month) (Day) (Year)

FULL NAME

Father
Emory H. RichardsonFULL
MAIDEN
NAMEMother
Ora Alta Kilcox

RESIDENCE

Cambridge Idaho

RESIDENCE

Cambridge Idaho

COLOR

White

AGE AT LAST
BIRTHDAY40
(Years)

COLOR

White

AGE AT LAST
BIRTHDAY31
(Years)

BIRTHPLACE

Malheur Co. Oregon

BIRTHPLACE

Michigan

OCCUPATION

Sheep-man

OCCUPATION

Housewife

Number of child of this mother, including present birth

6

Number of children of this mother now living, including present birth

6

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born on the date above stated.

Stillborn

(Born alive or stillborn)

11:00 A.M.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature)

J. W. Whitman

(Physician or midwife)

Given names added from a supplemental report.

Address

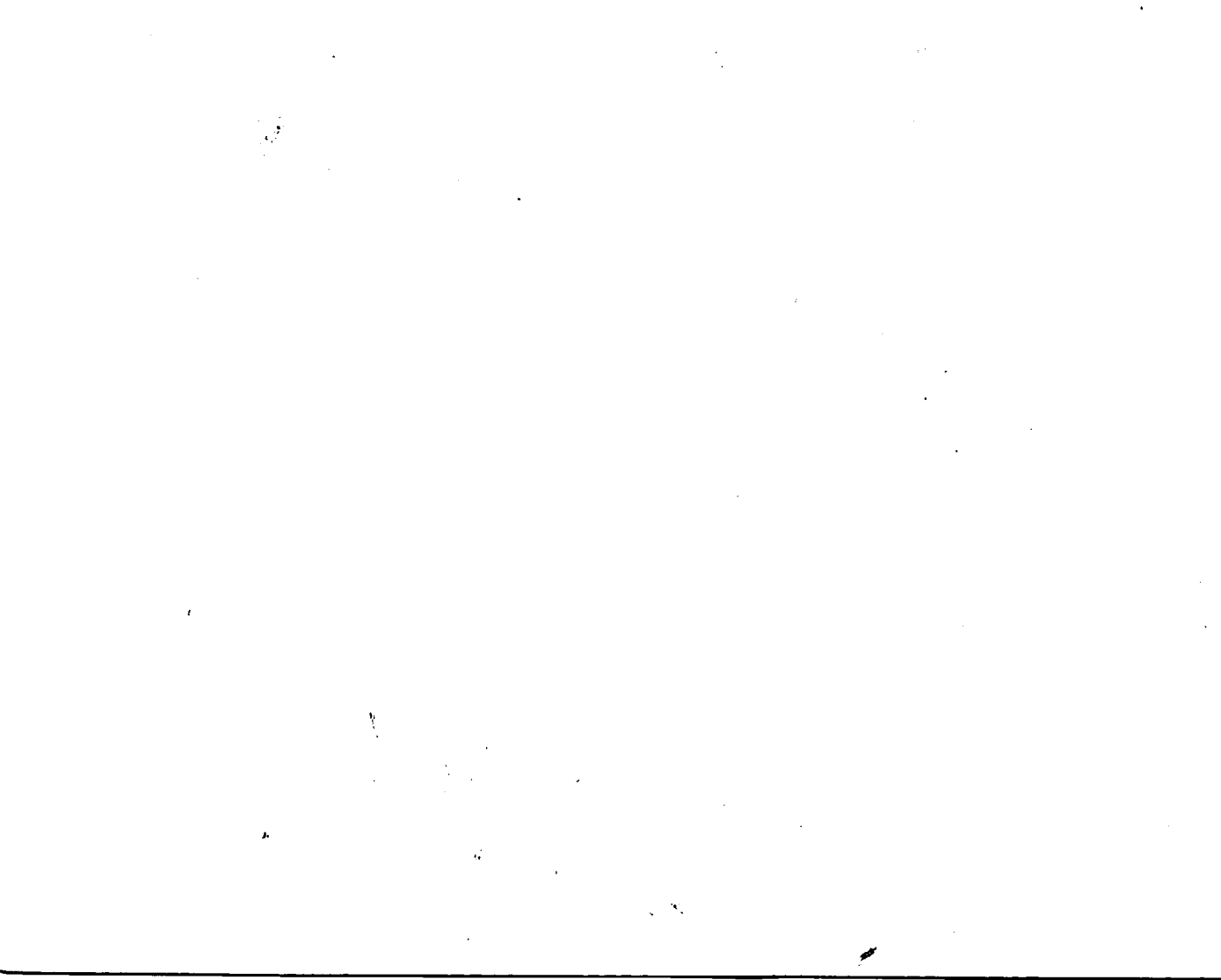
Cambridge Idaho

File

5-31-28

J. W. Whitman

Registrar



PLACE OF BIRTH

RECEIVED JAN 19 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

167694

County of SannockCity of PocatelloRegistration District No. 28

File No.

No. 440 N. Lincoln St.Hospital Pocatello GeneralPrimary Registration District No. 214Registered No. 2911

FULL NAME OF CHILD

Stillborn

Sex of Child

MaleTwin
Triplet
or other?

and

Number
in order
of birthLegiti-
mate?YesDate of
Birth1171928

(Month)

(Day)

(Year)

FULL
NAME

FATHER

Clark Russel PaulsonFULL
MAIDEN
NAME

MOTHER

Hazel West.

RESIDENCE

440 N. Lincoln

RESIDENCE

440 N. Lincoln

COLOR

WhiteAGE AT LAST
BIRTHDAY28
(Years)

COLOR

WhiteAGE AT LAST
BIRTHDAY27
(Years)

BIRTHPLACE

North Platte, Nebraska

BIRTHPLACE

Salt Lake City, Utah

OCCUPATION

Locomotive Fireman

OCCUPATION

HousewifeNumber of child of this mother, including present birth 1Number of children of this mother now living, including present birth 0

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was
on the date above stated.

at

2:30 P.

(Born alive or stillborn)

*When there was no attending physician or
midwife then the father, householder, etc.,
should make this return. A stillborn child is
one that neither breathes nor shows other evi-
dence of life after birth.

(Signature)

O. Hall

(Physician or midwife)

Given names added from a supplemental report.

19

Address

Pocatello, Idaho

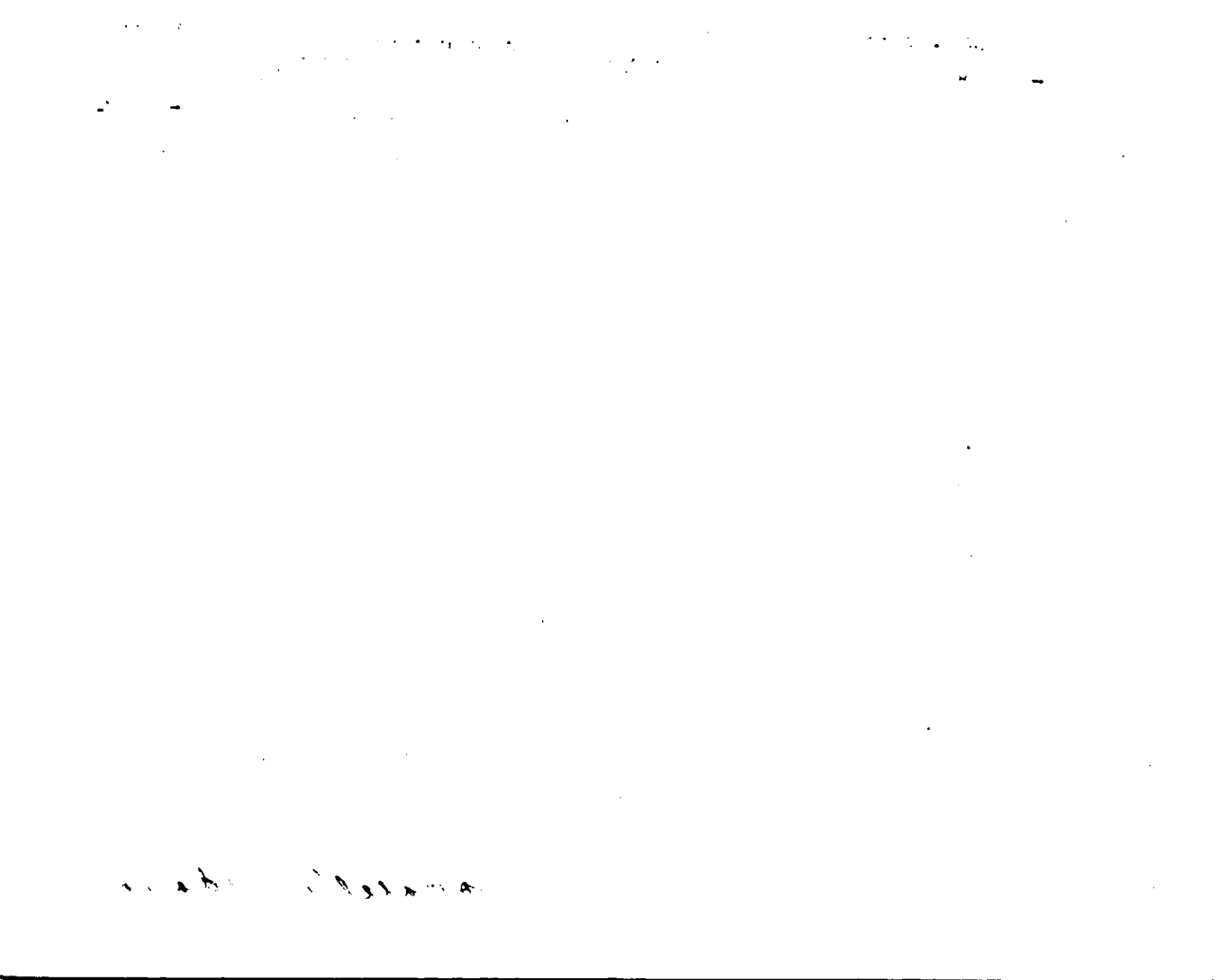
Filed

11 29

19

Registrar.

Registrar.



RECEIVED JAN 19 1928

PLACE OF DEATH

County of BANNOCK
City of POCATELLOSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2121Primary Registration District No. 2121(No. POCATELLO GENERAL HOSPITAL)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME RUSSELL WEST PAULSEN

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. Single, Married, Widowed, or Divorced (write the word) SINGLE5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Nov. 7, 19287. AGE Years Months Days If LESS than 1 day, hrs. or min.
STILL BORN

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) POCATELLO
(State or country) IDAHO.10. NAME OF FATHER CLARK R. PAULSEN11. BIRTHPLACE OF FATHER (city or town) NEBRASKA
(State or Country)12. MAIDEN NAME OF MOTHER HAZEL WEST13. BIRTHPLACE OF MOTHER (city or town) SALT LAKE CITY, UTAH.
(State or Country)14. Informant C. R. PAULSEN
(Address) POCATELLO, IDAHO.15. Filed 11/16, 1928

Registrar

DO NOT WRITE IN THIS SPACE

64361

State File No. _____

Local Registrar's No. 5453

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 7, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____ to _____, 19____
that I last saw him alive on Steel Bone, 19____
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Mother had Influenza
3 or 4 days before labor
(duration) _____ yrs. _____ mos. _____ ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? no Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Obd M. D.(Signed) 11/16, 1928 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

MOUNTAIN VIEWNov. 8, 1928

20. Undertaker

Address

ARTHUR W. HALLPOCATELLO

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECORDED JAN 19 1929
PLACE OF BIRTH

Form V. S. No. 11—20m-7-26-19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

S

367711 003-3741

County of BannockCity of PocatelloNo. 901 Idaho St.Registration District No. 27File No. 167697Hospital Pocatello GeneralPrimary Registration District No. 2161Registered No. 2994

FULL NAME OF CHILD

Stillborn

Sex of Child <u>male</u>	Twin Triplet or other? <u>—</u>	and	Number in order of birth <u>—</u>	Legitimate? <u>Yes</u>	Date of Birth <u>11 11 1928</u> (Month) (Day) (Year)
(To be answered only in event of plural births)					

FULL NAME FATHER Charles William CopleRESIDENCE 901 IdahoCOLOR White AGE AT LAST BIRTHDAY 42 (Years)BIRTHPLACE Robin, IdahoOCCUPATION Furniture manFULL MAIDEN NAME MOTHER Bessie Violet CrumpRESIDENCE 901 IdahoCOLOR AGE AT LAST BIRTHDAY 35 (Years)BIRTHPLACE Robin, IdahoOCCUPATION HousewifeNumber of child of this mother, including present birth 3 Number of children of this mother now living, including present birth 3

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was on the date above stated.

(Born alive or stillborn) 4:30 A.M.

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) O. K. Call

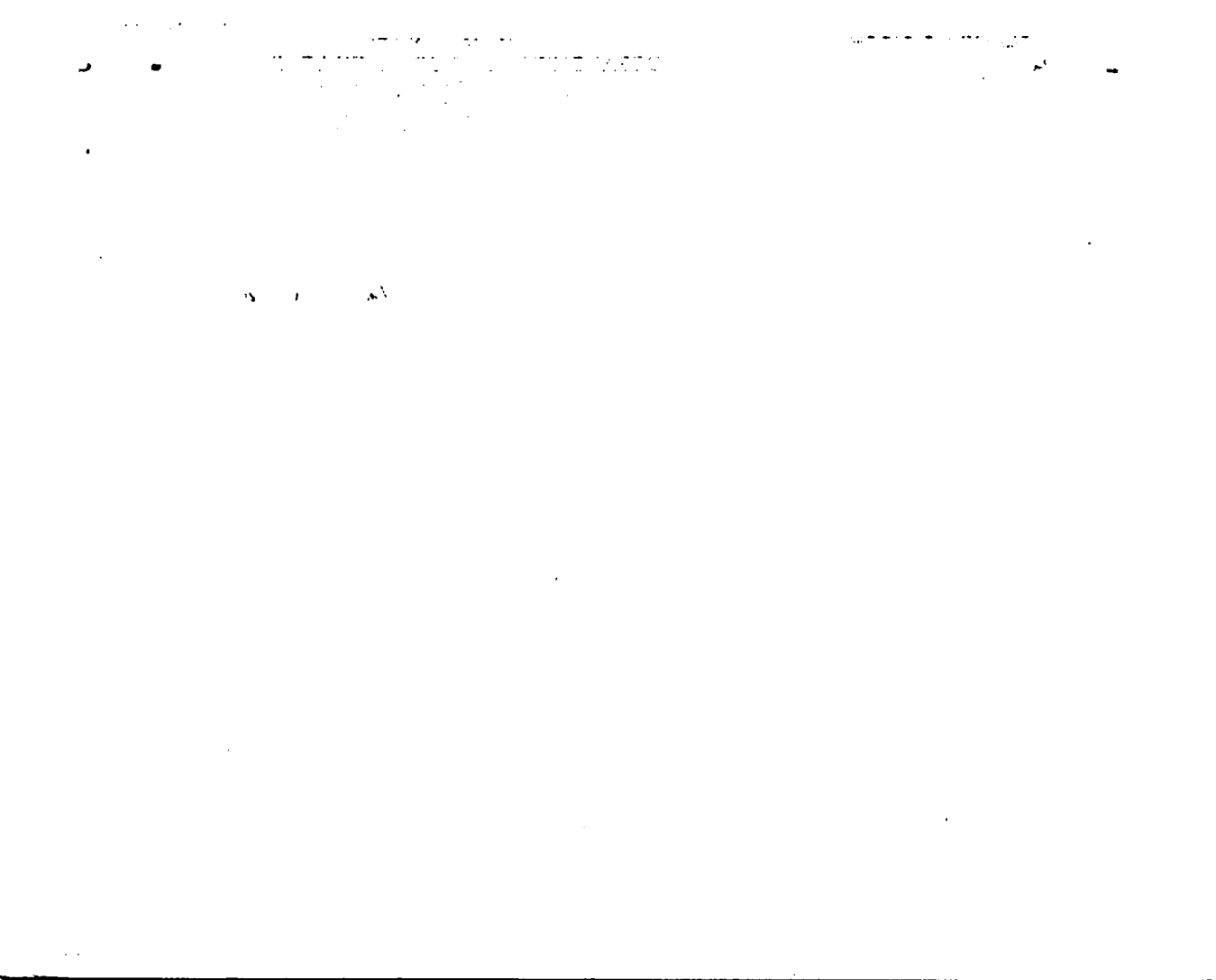
(Physician or midwife)

Given names added from a supplemental report.

Address Pocatello IdahoFiled 1/1 29

Registrar.

Registrar.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
 DEPARTMENT OF PUBLIC WELFARE
 BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **64363**

RECEIVED DEPT JAN 19 1929
 County of **BANNOCK**
 City of **POCATELLO**

Registration District No. **28**
 Primary Registration District No. **2161**
 (No. **GENERAL HOSPITAL**)
 (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. **5455**2. FULL NAME **INFANT CAPELL**

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **MALE** 4. COLOR OR RACE **WHITE** 5. Single, Married, Widowed, or Divorced (write the word) **SINGLE**
 5a. If married, widowed, or divorced **HUSBAND of (or) WIFE of**
 6. DATE OF BIRTH (month, day and year) **Nov. 11, 1928**
 7. AGE Years Months Days If LESS than 1 day, hrs. or min. **STILL BORN**
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **NONE**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (city or town) **POCATELLO, IDAHO.**
(State or country)10. NAME OF FATHER **CHARLES W. CAPELL**11. BIRTHPLACE OF FATHER (city or town) **ROBIN, IDAHO**
(State or Country)12. MAIDEN NAME OF MOTHER **BESSIE CRUMP**13. BIRTHPLACE OF MOTHER (city or town) **ROBIN, IDAHO.**
(State or Country)14. Informant **CHARLES W. CAPELL**
(Address) **R.F.D. #1, POCATELLO, IDAHO.**15. Filled **11/16, 1928** **W. Young** Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Nov. 11, 1928**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **11/11/28** to **Nov. 11, 1928**
 that I last saw him alive on _____, 19____
 and that death occurred, on the date stated above, at _____ m.
 The CAUSE OF DEATH* was as follows:

Still Born

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? **Off Head**

(Signed) _____, M. D.

_____, 19____ (Address) **Pocatello, Idaho**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal **ROBIN, IDAHO** Date of Burial **Nov. 11, 1928**20. Undertaker **ARTHUR W. HALL** Address **POCATELLO**

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

636-230003-466
PLACE OF BIRTH

County of Blaine IDAHO JAN 19 1929
City of Pocatello
No. St. Anthony St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

167714

Hospital Registration District No. 28 State File No. 167714
(If born in hospital or institution give name.)
Prim. Registration District No. 2161 Local Registrar's No. 7211
FULL NAME OF CHILD Mary Delight O'Connell
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of birth <u>11 - 30 - 1928</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 5 (a) Born alive and now living 3
Born alive but now dead 1 Stillborn 1

FATHER		MOTHER	
FULL NAME <u>Walter O'Connell</u>	FULL MAIDEN NAME <u>Delight Downing</u>		
Residence (Usual place of abode) <u>250 1st Ave</u>	Residence (Usual place of abode) <u>250 1st Ave</u>		
If nonresident, give place and State	If nonresident, give place and State		
Color or race <u>W</u> Age at last Birthday <u>41</u> (Years)	Color or race <u>W</u> Age at last Birthday <u>39</u> (Years)		
Birthplace <u>Grove Parrish, Wis.</u> (City and State or Country)	Birthplace <u>Woonsocket S.D.</u> (City and State or Country)		
Occupation <u>Employe A.S.E.</u>	Occupation <u>H.W.</u>		

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was {
on the date above stated. Born alive } at 8 20 P. M.
Stillborn

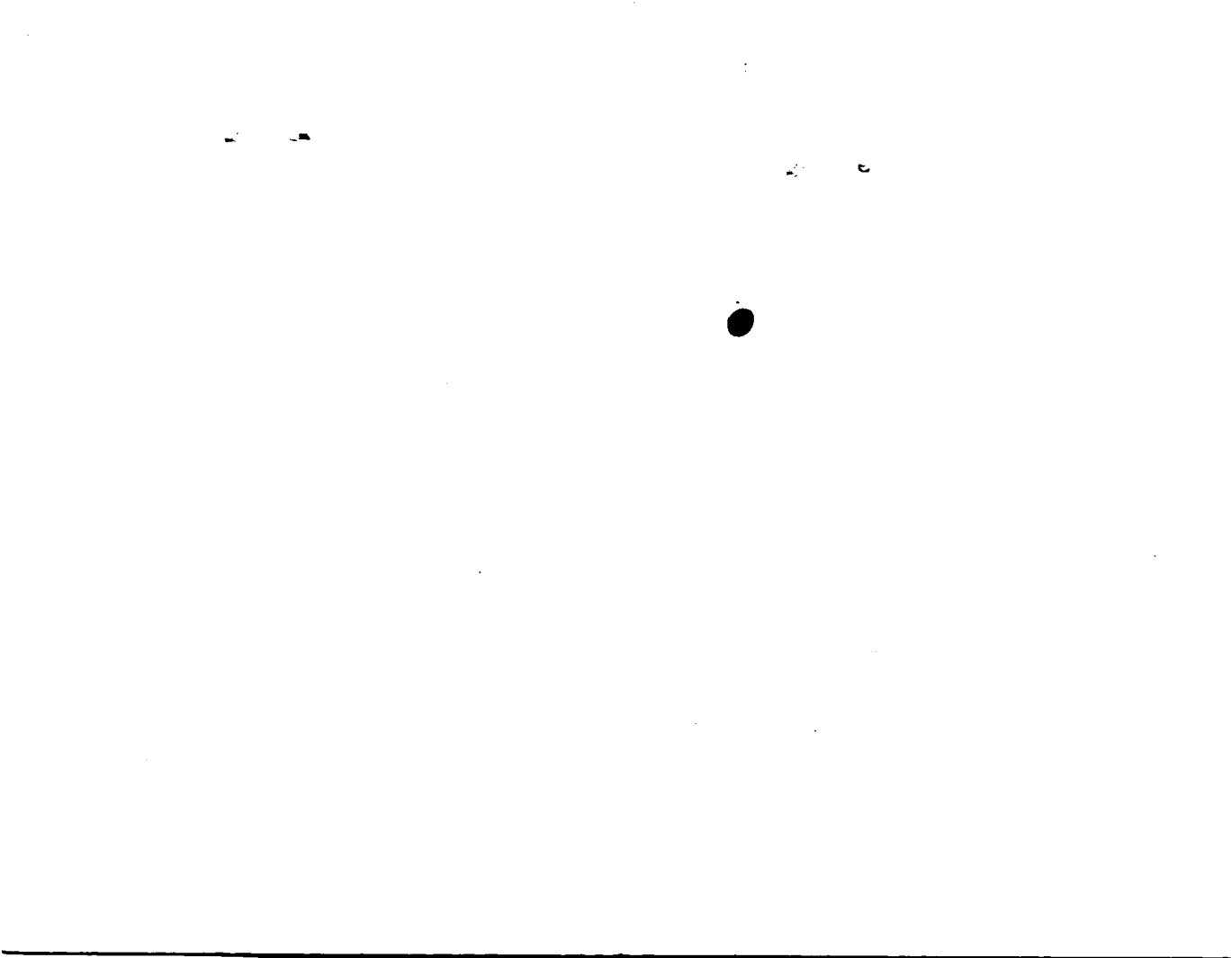
(Signature) [Signature]

(Physician or midwife)

Address Pocatello, Ida

Filed 11 1929 [Signature]
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
RECEIVED DEC 26 1928
PLACE OF DEATH
COUNTY OF Bannock
CITY OF Paris
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 63929

Registration District No. 2-8
Primary Registration District No. 2161
(No. St Anthony Hospital)
If death occurred in a hospital or institution, give its name instead of street and number.

2. FULL NAME Infant O'Connell
(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) _____
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6. DATE OF BIRTH (month, day and year) Nov 30-1928
7. AGE Years Months Days If LESS than 1 day, hrs. or min. Still Born
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Idaho
(State or country)
10. NAME OF FATHER W. S. O'Connell
11. BIRTHPLACE OF FATHER (city or town) Wis
(State or Country)
12. MAIDEN NAME OF MOTHER Schlegel
13. BIRTHPLACE OF MOTHER (city or town) S. Dakota
(State or Country)

14. Informant W. S. O'Connell
(Address) 250 1st Ave
15. Filed 12/4, 1928 W. J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 30, 1928
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 11-30, 1928, to 11-30, 1928, that I last saw her dead 11-30, 1928, and that death occurred, on the date stated above, at 7:30 p.m. The CAUSE OF DEATH* was as follows:
Still Born
abruptio placenta
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.
18. Where was disease contracted if not at place of death? _____
Did an operation precede death? no Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? Clinical
(Signed) W. J. Young M. D.
12/4, 1928 (Address) Paris

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View Bur Date of Burial Dec 1, 1928
20. Undertaker Shumacher & Son Address Any

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

267-501-003-766
PLACE OF BIRTH

County of BEAVER JAN 19 1929
City of Pocatello
No. 104 Woolley Apts

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH

Registration District No. 28 State File No. 167715

(If born in hospital or institution give name.)

Prim. Registration District No. 2161 Local Registrar's No. 1012

FULL NAME OF CHILD

Stillbirth

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin <u>—</u> Triplet <u>—</u> or other? <u>—</u> (To be answered only in event of plural births)	and {	Number in order of birth <u>—</u>	Legitimate? <u>Y</u>	Date of birth <u>12/1</u> (Month) (Day) (Year) <u>1928</u>
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What prophylactic was used to prevent Ophthalmia Neonatorum? 25% Argysol

Number of child of this mother, including present birth 1 (a) Born alive and now living 0

Born alive but now dead 0 Stillborn present one

FATHER
FULL NAME Clair Brown Lopez

MOTHER
FULL MAIDEN NAME Irene Ruth Powell

Residence (Usual place of abode) 104 Woolley Apts

Residence (Usual place of abode) 104 Woolley Apts

If nonresident, give place and State

If nonresident, give place and State

Color or race White Age at last Birthday 31 (Years)

Color or race White Age at last Birthday 28 (Years)

Birthplace Wellsburg Utah
(City and State or Country)

Birthplace Salt Lake City Utah
(City and State or Country)

Occupation Housewife

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 36 P M.
on the date above stated.

(Signature) O. H. Hall

(Physician or midwife)

Address Pocatello, Idaho

Filed 1/1 1929 W. J. H. H. Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

1. 1. 1.

1. 1. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 63932

DEC 20 1928
PLACE OF DEATH
County of BANNOCK
City of POCA TELLO
Registration District No. 28
Primary Registration District No. 2161
(No. GENERAL HOSPITAL)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5445

2. FULL NAME INFANT BAXTER

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE
4. COLOR OR RACE WHITE
5. Single, Married, Widowed, or Divorced (write the word) SINGLE
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) DEC. 1, 1928
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
STILL BORN
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work INFANT
(b) General nature of industry, business, or establishment in which employed (or employer) NONE
(c) Name of employer
9. BIRTHPLACE (city or town) POCA TELLO, IDA.
(State or country)
10. NAME OF FATHER CLAIN BAXTER
11. BIRTHPLACE OF FATHER (city or town) UTAH
(State or Country)
12. MAIDEN NAME OF MOTHER IRENE POWELL
13. BIRTHPLACE OF MOTHER (city or town) UTAH
(State or Country)
14. Informant CLAIN BAXTER
(Address) 104 WOOLEY APTS. POCA.
15. Filed 12/2, 1928
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH DEC. 1, 1928
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 1928
that I last saw h. alive on 1928
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Still Born
Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. Hall, M. D.
12/5, 1928 (Address) Pocahelld
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
19. Place of Burial, Cremation, or Removal Date of Burial
MOUNTAIN VIEW CEMETERY DEC. 3 1928
20. Undertaker Address
ARTHUR W. HALL POCA TELLO

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH Boise
County of Boise
City of Montpelier
No. 245116 St. 204-259
(If born in hospital or institution give name.)
Registration District No. 52 State File No. S167786
JAN 12 1928
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
Prim. Registration District No. 2136 Local Registrar's No. 52
FULL NAME OF CHILD Baby King
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and <u> </u>	Number in order of birth <u> </u>	Legitimate? <u>Yes</u>	Date of birth <u>Nov 16</u> 19 <u>28</u> (Month) (Day) (Year)
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What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 2
Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Carl J. King</u> Residence (Usual place of abode) <u>Montpelier</u> If nonresident, give place and State <u> </u> Color or race <u>White</u> Age at last Birthday <u>30</u> (Years) Birthplace <u>Idaho</u> (City and State or Country) Occupation <u>Laborer (Common)</u>	MOTHER FULL MAIDEN NAME <u>Lobby Bergman</u> Residence (Usual place of abode) <u>Montpelier</u> If nonresident, give place and State <u> </u> Color or race <u>White</u> Age at last Birthday <u>26</u> (Years) Birthplace <u>Idaho</u> (City and State or Country) Occupation <u>Inf</u>
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CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive Stillborn at 29 M.
on the date above stated.

(Signature) W. H. King, M.D.

(Physician or midwife)

Address Montpelier Idaho

Filed 12/20/28 1928 W. H. King

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

JAN 16 1975

noD

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED FEB 4 1929

STATE OF IDAHO

County of Boundary

DEPARTMENT OF PUBLIC WELFARE

City of Bonners Ferry

BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S167890

No. _____ St. _____

Bonners Ferry Hospital

Registration District No. 79

State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 2156 Local Registrar's No. _____

FULL NAME OF CHILD Robert Robel Krause

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of
Child

male

Twin
Triplet
or other? ✓
(To be answered only in event of plural births)

and {

Number
in order
of birth
(To be answered only in event of plural births)

Legiti-
mate? yes

Date of
birth

Oct. 19th

(Month)

(Day)

(Year)

1928

What prophylactic was used to prevent Ophthalmia Neonatorum? 12. 11. 1928

Number of child of this mother, including present birth 1

(a) Born alive and now living 1

Born alive but now dead 0

Stillborn 0

FULL
NAME

Wm Thomas Krause

FATHER

FULL
MAIDEN
NAME

Gwendolyn Robel

MOTHER

Residence (Usual place of abode)

Copeland, Ida.

Residence (Usual place of abode)

Copeland, Ida.

If nonresident, give place and State

If nonresident, give place and State

Color or race

white

Age at last Birthday

23

(Years)

Color or race

white

Age at last Birthday

23

(Years)

Birthplace

Copeland, Ida.

(City and State or Country)

Birthplace

Spokane, Wn.

(City and State or Country)

Occupation

Laborer - farmer

Occupation

Homemaker

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was

{ Born alive
Stillborn }

at 7:25 A. M.

on the date above stated.

(Signature)

E. E. Fry
Physician

(Physician or midwife)

Address

Bonners Ferry, Ida.

Filed

10/21/19 24.

E. E. Fry
Registrar

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

11/20/41

no
du

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

STATE OF IDAHO

County of Bonner

City of Bonner Ferry

No. _____ St. _____

962121011454

(If born in hospital or institution give name.)

Registration District No. 79

State File No. _____

Prim. Registration District No. 2156

Local Registrar's No. _____

FULL NAME OF CHILD

Thyde Austin Roberts

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child

Male

Twin
Triplet
or other?

✓

and

Number
in order
of birth

✓

Legiti-
mate?

yes

Date of
birth

Oct. 31st.

1928

(Month)

(Day)

(Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

1% Ag. No. 3

Number of child of this mother, including present birth

1

(a) Born alive and now living

0

Born alive but now dead

0

Stillborn

1

FATHER
FULL
NAME

Frank Alton Roberts

MOTHER
FULL
MAIDEN
NAME

Laura Meddick

Residence (Usual place of abode)

Garotney, Ida

Residence (Usual place of abode)

Garotney, Ida

If nonresident, give place and State

If nonresident, give place and State

Color or race

white

Age at last Birthday

23

(Years)

Color or race

white

Age at last Birthday

20

(Years)

Birthplace

Garfield, Wash.

(City and State or Country)

Birthplace

Bonner Ferry, Ida

(City and State or Country)

Occupation

Laborer

Occupation

Domestic

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

☒ Born alive
☐ Stillborn

at

4.30 A. M.

on the date above stated.

(Signature)

E. F. Fry
Physician

(Physician or midwife)

Address

Bonner Ferry, Ida

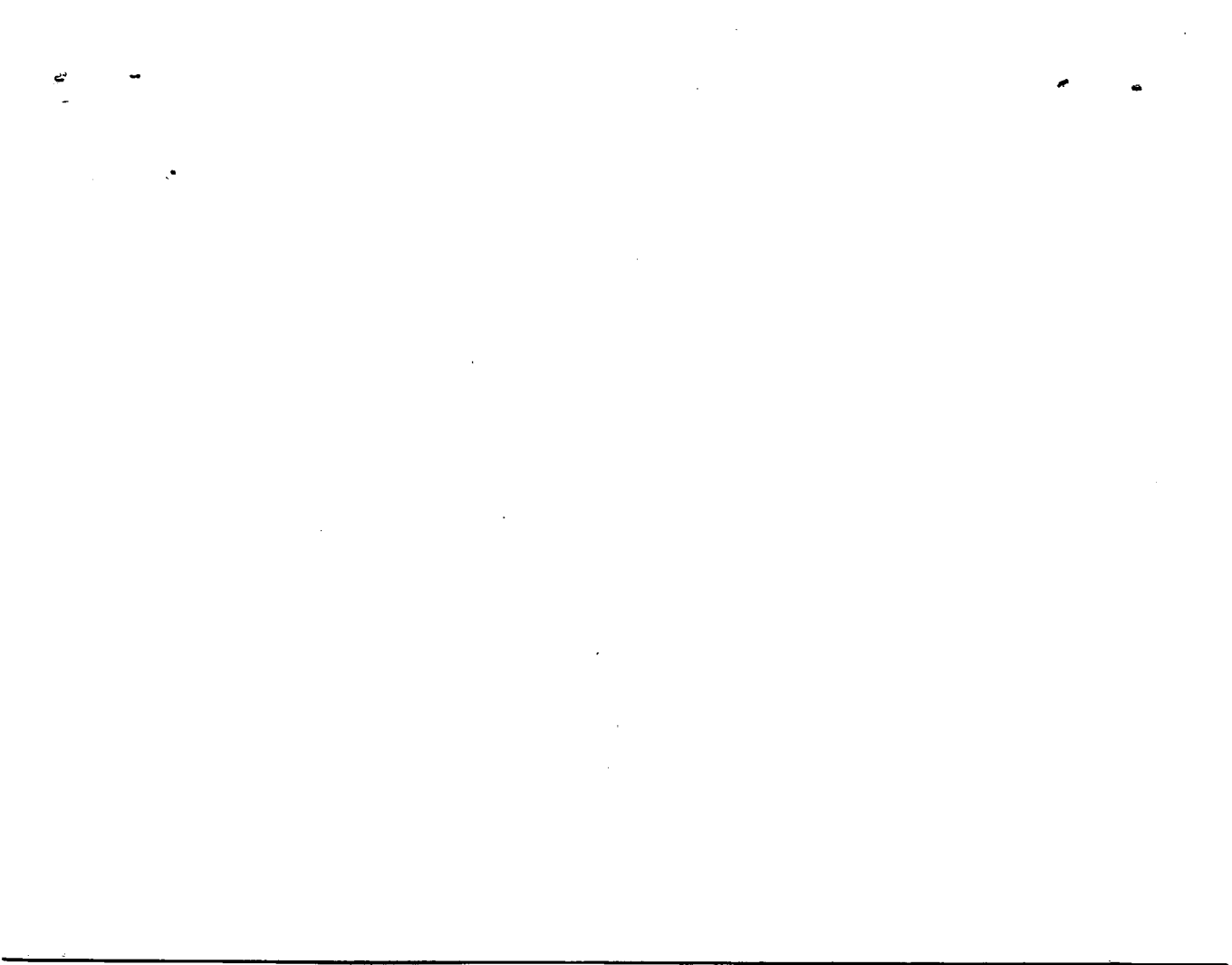
Filed

10/26/1928

E. F. Fry

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



RECEIVED FEB 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64471

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

Registration District No. 29

Primary Registration District No. 2154

Local Registrar's No.

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lloyd Austin Roberts

(a) Residence. No. _____ St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. Single, Married, Widowed,
or Divorced (write the word)6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

Oct. 21 - 1928

7. AGE

Years

Months

Days

If LESS than 1 day,

Stillborn

min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

Bonners Ferry

10. NAME OF FATHER

Frank Roberts

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Laura Meddock

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Idaho

14. Informant

(Address)

Frank Roberts

Bonners Ferry

15. Filed

Oct. 21, 1928

J. E. Fry, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 21, 1928

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19

to

, 19

that I last saw him alive on

, 19

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Stillborn

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

Difficult labor

(duration)

yrs.

mos.

ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Oct. 21, 1928 (Address)

J. E. Fry, M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT
CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2)
whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal

Date of Burial

Bonners Ferry, Oct. 21, 1928

20. Undertaker

Address

H. R. Crouch, Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

995-213-011-24)
PLACE OF BIRTH
County of Blaine
City of Bonners Ferry
No. St.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

Registration District No. 79 State File No. S 167897

Prim. Registration District No. 2157 Local Registrar's No.

(If born in hospital or institution give name.)

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child Female Twin Triplet or other? and Number in order of birth Legitimate? Yes Date of birth Aug 13 1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead Stillborn

FATHER
FULL NAME Geo Douglas Irving

Residence (Usual place of abode) Bonners Ferry Ida

If nonresident, give place and State

Color or race White Age at last Birthday 29 (Years)

Birthplace Rockford Ill (City and State or Country)

Occupation Postal Clerk

MOTHER
FULL MAIDEN NAME Lora Hughes

Residence (Usual place of abode) Bonners Ferry Ida

If nonresident, give place and State

Color or race White Age at last Birthday 27 (Years)

Birthplace Walden Colorado (City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at M. on the date above stated.

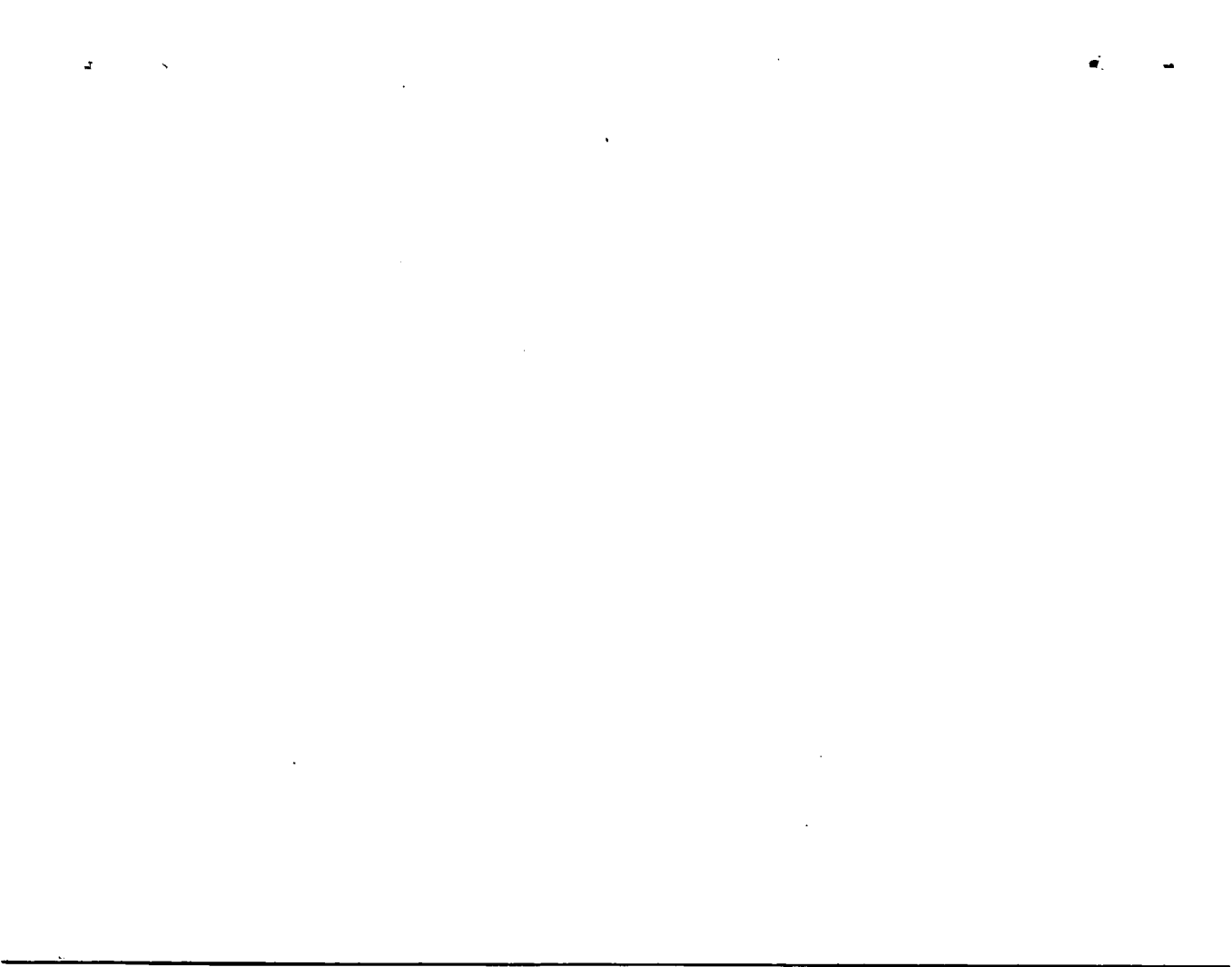
(Signature) Wm Bonnell

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)

Address Bonners Ferry Idaho

Filed Aug 20 1928 E. E. Ing Registrar



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 1 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. **64463**

PLACE OF DEATH
County of Boundary Registration District No. 29
City of Bonner Ferry Primary Registration District No. 2156 Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Irving
(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6. DATE OF BIRTH (month, day and year) Aug. 13 - 28
7. AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Bonner Ferry Idaho (State or country)
10. NAME OF FATHER Douglas Irving
11. BIRTHPLACE OF FATHER (city or town) Minnesota (State or Country)
12. MAIDEN NAME OF MOTHER Eva K. Irving
13. BIRTHPLACE OF MOTHER (city or town) Colorado (State or Country)

14. Informant Douglas Irving (Address) Bonner Ferry
15. Filed Aug. 13, 1928 J. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 13 - 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw h_____ alive on _____, 19____
and that death occurred, on the date stated above, at _____m.
The CAUSE OF DEATH* was as follows:
Stillborn

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Placental disease (Secondary)
(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
If not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? _____
(Signed) R. M. Boyle, M. D.
Aug 13, 1928 (Address) Bonner Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bonner Ferry Date of Burial Aug 14 1928
20. Undertaker R. P. Crouch Address Bonner Ferry

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of Cassia
City of Burley
No. 386-209016-284 St.

(If born in hospital or institution give name.)

RECEIVED JAN 21 1928
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S167996

Registration District No. 47 State File No. 2

Prim. Registration District No. 2196 Local Registrar's No. 276

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>Dec 2 1928</u> (Month) (Day) (Year)
-------------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 6 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn _____

FATHER FULL NAME <u>Henry Thompson</u>	MOTHER FULL MAIDEN NAME <u>Sarah Poulton</u>
---	---

Residence (Usual place of abode) Burley Ida

If nonresident, give place and State _____

Color or race White Age at last Birthday 38 (Years)

Birthplace Idaho (City and State or Country)

Occupation Laundry

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at Idaho on the date above stated. P. M.

(Signature) H. C. Cutler

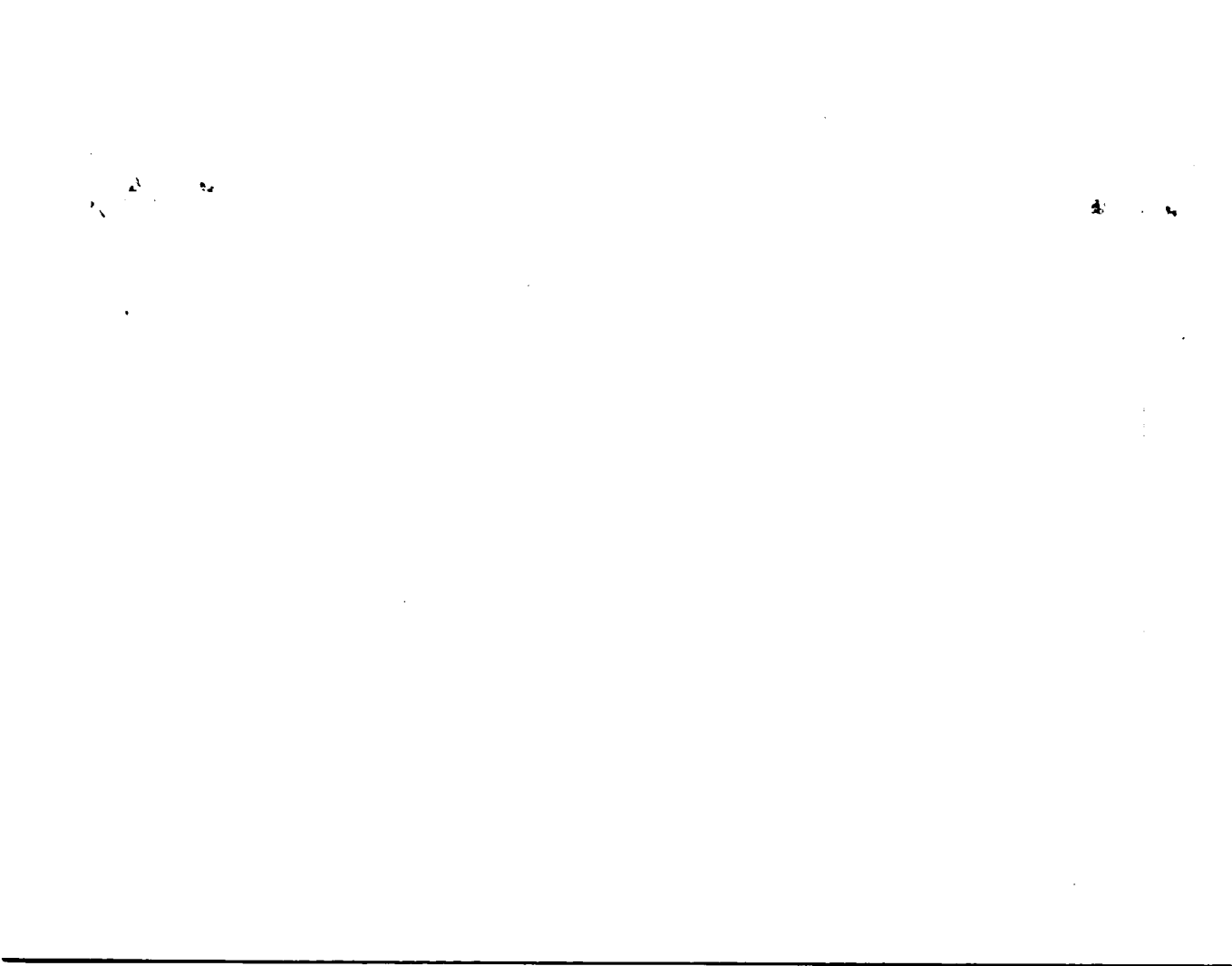
(Physician or midwife)

Address Burley Ida

Filed Jan 4 1928 Dr. H. C. Cutler

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.



RECEIVED JAN 31 1929

PLACE OF DEATH

County of CassiaCity of Burley

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 117Primary Registration District No. 2196

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME None

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Widowed5a. If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

8. DATE OF BIRTH (month, day and year)

7. AGE 20 Years 0 Months 0 Days 0 min. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (city or town) Burley
(State or country)10. NAME OF FATHER J. Henry Thompson11. BIRTHPLACE OF FATHER (city or town) Colo.
(State or Country)12. MAIDEN NAME OF MOTHER Sarah Boulton13. BIRTHPLACE OF MOTHER (city or town) _____
(State or Country)14. Informant Sarah P. Thompson
(Address) Burley15. Filled Jan 4, 1929 Dr. H. H. Butler
Registrar Chas. Street

DO NOT WRITE IN THIS SPACE

State File No. 64519Local Registrar's No. 21

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 8 1928

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

I don't knowBody was a macerated
(duration) yrs. mos. ds. factisCONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) F. H. Butler, M. D._____, 19____ (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal _____ Date of Burial _____

19

20. Undertaker _____ Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Cassia
City of
No. St.
766-209-116-893
(If born in hospital or institution give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH
167998

Registration District No. 117 State File No.
Prim. Registration District No. 2196 Local Registrar's No. 303

FULL NAME OF CHILD
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twins or other? <u>Triplet</u>	and { Number in order of birth }	Legitimate? <u>yes</u>	Date of birth <u>12 9 1928</u> (Month) (Day) (Year)
----------------------------	--------------------------------	----------------------------------	------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? —

Number of child of this mother, including present birth 9 (a) Born alive and now living 5
Born alive but now dead 2 Stillborn 2

FATHER	MOTHER
FULL NAME <u>George Alfred Good</u>	FULL MAIDEN NAME <u>Mary Emma Hicks</u>
Residence (Usual place of abode) <u>Burley Idaho</u>	Residence (Usual place of abode) <u>Burley Idaho</u>
If nonresident, give place and State <u>—</u>	If nonresident, give place and State <u>—</u>
Color or race <u>white</u> Age at last Birthday <u>41</u> (Years)	Color or race <u>white</u> Age at last Birthday <u>34</u> (Years)
Birthplace <u>Hanksville Utah</u> (City and State or Country)	Birthplace <u>Monroe Utah</u> (City and State or Country)
Occupation <u>Farmer</u>	Occupation <u>Housewife</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 930 P. M.
on the date above stated.

(Signature) H. B. Steward M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address Burley Idaho
Filed Jan 22 1929 Dr. H. B. Steward Registrar.
M. J. Greco

• 21. 22.

RECEIVED JAN 31 1929 STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64520

PLACE OF DEATH

County of Cassia
City of BurleyRegistration District No. 117Primary Registration District No. 2196Local Registrar's No. 21(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Baby Goold

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W 5. Single, Married, Widowed, or Divorced (write the word) Single

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____

6. DATE OF BIRTH (month, day and year) Dec. 9/1928

7. AGE Years Months Days Still Born min. hrs. or LESS than 1 day,

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (city or town) Burley Ida
(State or country)10. NAME OF FATHER George A Goold11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)12. MAIDEN NAME OF MOTHER Mary Geneva Hicks13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)14. Informant G A Goold
(Address) Burley Ida15. Filed Jan 4, 1929 Dr. J. C. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 9 1928
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 9, 1928, to _____, 19____
that I last saw h. _____ alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:Still born
(duration) _____ yrs. _____ mos. _____ ds.CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.18. Where was disease contracted _____
if not at place of death? _____Did an operation precede death? _____ Date of Dec 9-1928

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) W. B. Steward, M. D.Dec 10, 1928 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida Date of Burial Dec 10 192820. Undertaker D. E. Johnson Address Burley

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
County of <u>Custer</u>		DEPARTMENT OF PUBLIC WELFARE	
City of <u>Challis</u>		BUREAU OF VITAL STATISTICS	
		CERTIFICATE OF BIRTH	
No. <u>762-102-019-253</u>	St. <u>253</u>	Registration District No. <u>108</u>	State File No. <u>168054</u>
(If born in hospital or institution give name.)		Prim. Registration District No. <u>2186</u>	Local Registrar's No. <u>174</u>
FULL NAME OF CHILD <u>Stillborn</u>			
(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and Number in order of birth	Legitimacy <u>yes</u>
Date of birth <u>Nov. 2</u>	(Month)	(Day)	(Year) <u>1928</u>
What prophylactic was used to prevent Ophthalmia Neonatorum?			
Number of child of this mother, including present birth (a) Born alive and now living			
Born alive but now dead Stillborn <u>1</u>			
FULL NAME <u>Leo Gessi</u>	FATHER	FULL MAIDEN NAME <u>Eva Kelley</u>	MOTHER
Residence (Usual place of abode) <u>Clayton, Ida</u>		Residence (Usual place of abode) <u>May, Idaho</u>	
If nonresident, give place and State		If nonresident, give place and State	
Color or race <u>White</u>	Age at last Birthday <u>29</u>	Color or race <u>W. It</u>	Age at last Birthday <u>18</u>
(Years)		(Years)	
Birthplace <u>Clayton, Idaho</u>	(City and State or Country)	Birthplace <u>May, Idaho</u>	(City and State or Country)
Occupation <u>Harmer</u>		Occupation <u>Housewife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } at Idaho M.
on the date above stated. { Stillborn }

(Signature) E. L. M. H. M. D.

(Physician or midwife)

Address Challis, Idaho

Filed Jan 91 1929

Registrar. Edna M. Conroy

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

2

3

4

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64569

PLACE OF DEATH
County of Custer
City of Challis

Registration District No. 128
Primary Registration District No. 2186

Local Registrar's No. 86

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stillborn

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 2, 1928

7. AGE Years 0 Months 0 Days 0 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Challis, Idaho
(State or country)

10. NAME OF FATHER Leo Rossi

11. BIRTHPLACE OF FATHER (city or town) Clayton
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Eva Kelley

13. BIRTHPLACE OF MOTHER (city or town) May
(State or Country) Idaho

14. Informant Leo Rossi
(Address) Clayton, Idaho

15. Filed Jan 31, 1929 Elena McKenney
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 2, 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
that I last saw him alive on _____, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

not known

CONTRIBUTORY (Secondary) _____
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) E. S. Kirby M. D.
Jan 31, 1929 (Address) Challis

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Challis, Idaho Date of Burial Nov. 2, 1928

20. Undertaker Relatives Address Challis, Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
County of <u>Fremont</u>		DEPARTMENT OF PUBLIC WELFARE	
City of <u>Newdale</u>		BUREAU OF VITAL STATISTICS	
No. <u>264102022613</u> St.		CERTIFICATE OF BIRTH	
(If born in hospital or institution give name.)		Registration District No. <u>99</u>	State File No. <u>168118</u>
FULL NAME OF CHILD <u>Stillborn</u>		Prim. Registration District No. <u>2177</u> Local Registrar's No. <u>532</u>	
(If stillborn, substitute the word "Stillbirth" for name of child)			
Sex of Child <u>male</u>	Twin Triplet or other? <u>1</u>	and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>
(To be answered only in event of plural births)		Date of birth <u>Sept. 2nd 1928</u>	(Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum? <u>Still Born</u>			
Number of child of this mother, including present birth <u>1</u> (a) Born alive and now living <u>0</u>			
Born alive but now dead <u>1</u> Stillborn <u>1</u>			
FATHER FULL NAME <u>Ernest Lorenzo Young</u>		MOTHER FULL MAIDEN NAME <u>Edith Pearl Watts</u>	
Residence (Usual place of abode) <u>Newdale</u>		Residence (Usual place of abode) <u>Newdale</u>	
If nonresident, give place and State <u>✓</u>		If nonresident, give place and State <u>✓</u>	
Color or race <u>W.</u> Age at last Birthday <u>29</u> (Years)		Color or race <u>W.</u> Age at last Birthday <u>21</u> (Years)	
Birthplace <u>Preston Ida</u> (City and State or Country)		Birthplace <u>Beautiful, Utah</u> (City and State or Country)	
Occupation <u>Janitor</u>		Occupation <u>Wife</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was { Born alive } at 1 a. M.
on the date above stated. (Signature) D. M. Kelly, M.D.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Physician or midwife)
Address St. Anthony, Ida.
Filed 10/4 19 28 Corbin
Registrar.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 14 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 64592

PLACE OF DEATH

County of *Fremont*
City of *Newdale*

Registration District No. *99*
Primary Registration District No. *2177*

Local Registrar's No. *255*

(No. _____)

If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME, *Baby Young Junior*

(a) Residence, No. _____ St. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX *Male* 4. COLOR OR RACE *White* 5. Single, Married, Widowed, or Divorced (write the word) _____

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) *Sept. 2nd, 1928*

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) *Newdale Idaho*
(State or country)10. NAME OF FATHER *Ernest L. Young*11. BIRTHPLACE OF FATHER (city or town) *Preston Idaho*
(State or Country)12. MAIDEN NAME OF MOTHER *Edith Paul Watts*13. BIRTHPLACE OF MOTHER (city or town) *Pompliful Idaho*
(State or Country)14. Informant *Ernest L. Young*
(Address) *Newdale Idaho*15. Filed *9/2*, 19*28* *W. M. Hansen*
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Sept. 2nd* 19*28*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept. 2nd*, 19*28*, to *Sept. 2*, 19*28*
that I last saw him alive on *Sept. 2*, 19*28*
and that death occurred, on the date stated above, at *Birth* m.

The CAUSE OF DEATH* was as follows:

Still Born
Mal-formed Cord
Constricted
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) *Roger Kelly*, M. D.
Sept. 2, 19*28* (Address) *S. H. Anthony, Idaho*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *Newdale* Date of Burial *Sept. 3rd* 19*28*
Address _____

20. Undertaker *None*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6-yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

PLACE OF BIRTH RECEIVED JAN 1 1900

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of FremontCity of Chester

CERTIFICATE OF BIRTH

168145

No. 625-10202-793 St.Registration District No. 99

State File No.

Hospital

Primary Registration District No. 2177Local Registrar's No. 559

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of
ChildmaleTwin
Triplet
or other?1

} and {

Number
in order
of birth3Legiti-
mate?yesDate of
birthOct. 2, 19281928

(To be answered only in event of plural births)

(Month)

(Day)

(Year)

What bactericidal solution was used in eyes?

Still BornNumber of child of this mother, including present birth 3Number of child of this mother now living, including present birth 0FULL
NAME

FATHER

Carl Hymen Oberhansley

RESIDENCE

Chester, Ida.

COLOR

WhiteAGE AT LAST
BIRTHDAY34
(Years)

BIRTHPLACE

Payson, Utah

OCCUPATION

FarmerFULL
MAIDEN
NAME

MOTHER

Alta Julia Gilbert

RESIDENCE

Chester, Ida.

COLOR

WhiteAGE AT LAST
BIRTHDAY19
(Years)

BIRTHPLACE

Chester, Ida.

OCCUPATION

Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 3³⁰ a. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature)

P. M. Kelly, M.D.

(Physician or midwife)

Address

St Anthony, Ida.

Filed

11/5 1928Wm. Hansen

Registrar.

Registrar.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

RECEIVED JAN 14 1929

PEACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

64593

State File No.

County of Tremont
City of ChesterRegistration District No. 99Primary Registration District No. 2177Local Registrar's No. 256(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Stella Bern Oberhansley

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word)5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) 10-2-187. AGE Years Months Days If LESS than 1 day, hrs. or min.
- - - - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Chester Idaho
(State or country)10. NAME OF FATHER Care Oberhansley11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)12. MAIDEN NAME OF MOTHER Altha Culbert13. BIRTHPLACE OF MOTHER (city or town) Chester Idaho
(State or Country)14. Informant Care Oberhansley
(Address) Chester Idaho15. Filed 10/2, 1928 COM. Hansen
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10-2-28
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-2-, 1928, to 10-2-, 1928
that I last saw him live on 10-2-, 1928
and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH* was as follows:

Premature prolapse of cord(duration) yrs. mos. 1.0 min.CONTRIBUTORY
(Secondary)Abnormal position of child

(duration) yrs. mos. ds.

18. Where was disease contracted
if not at place of death? ✓Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Findings(Signed) P. M. Kelly, M. D.10-2-, 1928 (Address) St. Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ashton Idaho Date of Burial 10/3 192820. Undertaker James Kiser Address Ashton Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH
County of Idaho
City of Grangeville
No. 363 205 025-369 St.

(If born in hospital or institution
give name.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S
168209

Registration District No. 103 State File No.

Prim. Registration District No. 2151 Local Registrar's No. 7808

FULL NAME OF CHILD No name Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and	Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Sept. 5</u> (Month) (Day)	<u>1928</u> (Year)
----------------------------	---	-----	--------------------------------	-----------------------------	--	-----------------------

What prophylactic was used to prevent Ophthalmia Neonatorum? none

Number of child of this mother, including present birth 2 (a) Born alive and now living 1

Born alive but now dead none Stillborn 1

FATHER
FULL NAME William Clayton Collins

Residence (Usual place of abode) Grangeville

If nonresident, give place and State

Color or race white Age at last Birthday 25
(Years)

Birthplace Stites, Idaho
(City and State or Country)

Occupation laborer

MOTHER
FULL MAIDEN NAME Pearl Ann York

Residence (Usual place of abode) Grangeville, Ida

If nonresident, give place and State

Color or race white Age at last Birthday 19
(Years)

Birthplace Stites, Idaho
(City and State or Country)

Occupation housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive at 1:00 A. M.
on the date above stated.

(Signature) J. D. Shinnick M.D.

Physician
(Physician or midwife)

Address

Filed 2-1- 1927 B. Chipman

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

RECEIVED FEB 6 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. **64616**

PLACE OF DEATH

County of IdahoCity of GrangevilleRegistration District No. 103Primary Registration District No. 2181Local Registrar's No. 3(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)2. FULL NAME Stillbirth

(a) Residence. No. _____ St. _____

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of6. DATE OF BIRTH (month, day and year) Sept. 5, 19287. AGE Years Months Days If LESS than 1 day, hrs. or min.
no min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Grangeville, Idaho
(State or country)10. NAME OF FATHER Wm. Dayton Collins11. BIRTHPLACE OF FATHER (city or town) Stites, Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Pearl Ann York13. BIRTHPLACE OF MOTHER (city or town) Stites, Idaho
(State or Country)14. Informant Dr. J. D. Shinnick
(Address) Grangeville, Idaho15. Filed 2-4- 1929 B Chipman
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 5, 1928
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 9-5- 1928, to 9-5- 1928
that I last saw her alive on never, 19____
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:
Stillborn(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY none
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? no diseaseDid an operation precede death? no Date of _____Was there an autopsy? noWhat test confirmed diagnosis? none(Signed) J. D. Shinnick, M. D.2-3- 1929 (Address) Grangeville, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville, Ida. Date of Burial 9-6- 1928

20. Undertaker _____ Address _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

363-226-030-849
PLACE RECEIVED JAN 17 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S 168266

County of Idaho
City of Salmon
No. _____ St. _____

Registration District No. 41 State File No. _____

(If born in hospital or institution
give name.)

Prim. Registration District No. 2/16 Local Registrar's No. _____

FULL NAME OF CHILD _____

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Female</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Y</u>	Date of birth <u>Nov 26</u> 192 <u>8</u> (Month) (Day) (Year)
----------------------------	---	--------------------------------------	---------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 3 (a) Born alive and now living 2

Born alive but now dead _____ Stillborn _____

FATHER
FULL NAME Frank Lockyer

Residence (Usual place of abode) Salmon

If nonresident, give place and State _____

Color or race Wh Age at last Birthday 29 (Years)

Birthplace Idaho (City and State or Country)

Occupation Rancher

MOTHER
FULL MAIDEN NAME Jessie Quinn

Residence (Usual place of abode) Salmon

If nonresident, give place and State _____

Color or race Wh Age at last Birthday 24 (Years)

Birthplace Idaho (City and State or Country)

Occupation Wife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born at 330 P. on the date above stated.

(Signature) F. Wright

(Physician or midwife)

Address Salmon

Filed Jan 10 1929 Chas Bellamy
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

DoD

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

RECEIVED

JAN 26 1928

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of My Percel

City of My Percel

CERTIFICATE OF BIRTH

No. St. Registration District No. 128 State File No. 168302

Hospital Primary Registration District No. Local Registrar's No.

FULL NAME OF CHILD Stillborn

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? <u> </u>	and { Number in order of birth <u> </u>	Legitimate? <u>yes</u>	Date of birth <u>11</u> <u>19</u> <u>1928</u>
(To be answered only in event of plural births)			(Month)	(Day) (Year)

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth 8 Number of child of this mother now living, including present birth 4

FATHER
FULL NAME James Miles
RESIDENCE Caldesac Idaho
COLOR Indian 4/4 AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Montana
OCCUPATION Farmer

MOTHER
FULL MAIDEN NAME Kettie Williams
RESIDENCE Caldesac Idaho
COLOR Indian 4/4 AGE AT LAST BIRTHDAY 35 (Years)
BIRTHPLACE Washington
OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Stillborn at 2:30 P. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report., 1928

(Signature) George Gaillard
Physician
(Physician or midwife)

Address Caldesac Idaho

Filed Nov. 1928 George Gaillard
Registrar.

RECEIVED BY THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA
 IN THE MATTER OF THE ESTATE OF JAMES EARL RAY, JR.
 DECEASED
 BY ORDER OF THE COURT
 DATED 10/10/68
 AT WASHINGTON, D.C.

STATE OF IDAHO
 DEPARTMENT OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF BIRTH

County of _____
 City of _____
 No. _____
 Registration District No. _____
 State File No. 103305

Parent's Registration District No. _____
 Local Registration No. _____

Full Name of Child _____
 (Certificate of the name without full name of child)

Sex of Child _____
 (To be answered only in event of plural births)

Number of Births _____
 (To be answered only in event of plural births)

Month of Birth _____
 Day of Birth _____
 Year of Birth _____

Place of Birth _____
 (To be answered only in event of plural births)

Number of child of this mother, including present birth _____
 Name of Mother _____
 Full Name _____
 Maiden Name _____

Number of child of this father, including present birth _____
 Name of Father _____
 Full Name _____
 Maiden Name _____

Color _____
 Birth Date _____
 Birth Place _____
 Occupation _____

Color _____
 Birth Date _____
 Birth Place _____
 Occupation _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
 I hereby certify that I attended the birth of this child, who was _____
 on the date above stated.
 When there was no attending physician or midwife then the father, householder, or neighbor makes this report. A statement should be made when a statement is made that neither father nor mother shows other evidence of the birth.
 (Signature of physician or midwife) _____
 (Signature of father, householder, or neighbor) _____
 Address _____
 Date _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. ~~REV. 6-26-17~~ JAN 26 1929

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Key Perce
City of Webb Idaho

Registration District No. 128

Primary Registration District No. _____

(No. _____ St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn

State File No. 64681

Local Registrar's No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male Indian 4/4

(Write the word)

6. DATE OF BIRTH

Nov 19 1928
(Month) (Day) (Year)

7. AGE

IF LESS than 1
day how many
_____ hrs. or
_____ min.?

_____ Yrs. _____ Mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF
Father

James Miles

11. BIRTHPLACE
OF FATHER

(State or Country) Montana

12. MAIDEN NAME
OF MOTHER

Nettie Williams

13. BIRTHPLACE
OF MOTHER

(State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James Miles
Caldes Idaho

15.

Filed

Nov.

1928

George Gagnard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 19 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19 to 19,

that I last saw h. alive on 19,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

George Gagnard M. D.
Nov. 1928 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Webb Idaho

DATE OF BURIAL

11-19 1928

20. UNDERTAKER

Family

ADDRESS

Caldes Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "**Laborer, Foreman, Manager, Dealer, etc.,** without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "**Epidemic cerebrospinal meningitis**"); **Diphtheria** (avoid use of "**Croup**"); **Typhoid fever** (never report "**Typhoid Pneumonia**") **Lobar pneumonia; Brouchopneumonia** ("**Pneumonia**," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc.,** of (name origin; "**Cancer**" is less definite; avoid use of "**Tumor**" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Brouchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "**Asthenia, Anaemia**" (merely symptomatic), "**Atrophy, Collapse, Coma, Convulsions, Debility, Congenital, Senile,**" etc.), "**Dropsy, Exhaustion, Heart Failure, Hemorrhage, Inanition, Marasmus, Old age, Shock, Uraemia, Weakness,**" etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia, PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "**Contributory.**"

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH

469-106 040-817

RECEIVED JAN 16 1928

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

County of Shoshone

City of Wallace

CERTIFICATE OF BIRTH

S - - -
168343

No. St. Registration District No. 70 State File No.

Hospital Wallace Primary Registration District No. 121 Local Registrar's No. 114

FULL NAME OF CHILD

(Certificate of no value without full name of child)

Sex of Child <u>Male</u>	<input type="checkbox"/> Twin <input type="checkbox"/> Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legitimate? <u>Yes</u>	Date of birth <u>10-5</u> 192 <u>8</u> (Month) (Day) (Year)
--------------------------	---	--------------------------------	------------------------	--

What bactericidal solution was used in eyes?

Number of child of this mother, including present birth Number of child of this mother now living, including present birth

FULL NAME <u>William Moriarty</u>	FATHER
RESIDENCE <u>Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>37</u> (Years)
BIRTHPLACE <u>Ireland</u>	
OCCUPATION <u>Millman</u>	

FULL MAIDEN NAME <u>Rose Haggans</u>	MOTHER
RESIDENCE <u>Idaho</u>	
COLOR <u>White</u>	AGE AT LAST BIRTHDAY <u>33</u> (Years)
BIRTHPLACE <u>Ireland</u>	
OCCUPATION <u>H. W.</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9 30 M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report., 192

(Signature)

R. Werlich

(Physician or midwife)

Address

Wallace Idaho

Filed

Dec 15 1928

H. R. Riegley

Registrar.

Registrar.

CERTIFICATE OF BIRTH

No. 100343 Registration District No. 1 State File No. 1
 Hospital Woburn Birth Registration District No. 1 Hospital Registration No. 1

FULL NAME OF CHILD

(Certificate of no living without full name of child)

Sex of Male Female Other None
 Date of Birth 1911 1912 1913 1914 1915 1916 1917 1918 1919 1920
 (To be inserted only in case of illegals)

What particular notation was used in case

Name of child in this mother, including present birth

Number of child of this mother now living, including this child

OTHER NAME FULL NAME

RESIDENCE

COLOR

AGE AT LAST BIRTHDAY

BIRTHPLACE

OCCUPATION

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of the child, who was born at Woburn on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither practices nor shows other evidence of life after birth.

Give names added from a supplemental report

132

Address

Physician or midwife

Signature

Notary

132

132

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 16 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 64638

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 72

Local Registrar's No. 142

Primary Registration District No. 1011

(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Dorothy

(a) Residence. No. Gen Idaho St. Gen Idaho

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Still born If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Wallace Idaho (State or country)

10. NAME OF FATHER Wm Dorrity

11. BIRTHPLACE OF FATHER (city or town) Ireland (State or Country)

12. MAIDEN NAME OF MOTHER Rose Higgins

13. BIRTHPLACE OF MOTHER (city or town) Ireland (State or Country)

14. Informant Wm Dorrity (Address) Gen Idaho

15. Filed 1928 W. A. G. G. G. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 6 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1928, to Dec 6 1928

that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH was as follows:

Still born (due to placental changes)

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm Dorrity M. D.

Dec 7 1928 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace Idaho Date of Burial Dec 6 1928

20. Undertaker Ward Undertaking Co. Address Wallace Idaho

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH *Idaho* STATE OF IDAHO *September 1928*
County of *Ft. Hall Reservation* DEPARTMENT OF PUBLIC WELFARE
Idaho. BUREAU OF VITAL STATISTICS
City of _____
No. *343 130 306-113* RECEIVED MAR 8 1929 CERTIFICATE OF BIRTH
Registration District No. *121* State File No. *168582*
(If born in hospital or institution give name.) Prim. Registration District No. *2194 R* Local Registrar's No. *35*

FULL NAME OF CHILD *Allen Cutler*

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <i>Male</i>	Twins } and { Triplet } or other? } (To be answered only in event of plural births)	Number in order of birth	Legitimate? <i>Yes</i>	Date of birth <i>Sept. 30, 1928</i> (Month) (Day) (Year)
--------------------------	--	--------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? -----

Number of child of this mother, including present birth *3* (a) Born alive and now living *1*
Born alive but now dead *0* Stillborn *2*

FATHER
FULL NAME *Andrew Cutler*
Residence (Usual place of abode) *Ft. Hall Reserv.*

If nonresident, give place and State _____
Color or race *Shoshone Ind. 1/4* Age at last Birthday *32* (Years)
Birthplace *Mo. Cammon, Idaho*
(City and State or Country)
Occupation *Farming*

MOTHER
FULL MAIDEN NAME *Esther Louvina Webber*
Residence (Usual place of abode) *Same*

If nonresident, give place and State _____
Color or race *White* Age at last Birthday *29* (Years)
Birthplace *Humbolt, Iowa*
(City and State or Country)
Occupation *Housewife*

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was *Not Stillborn* at *11.15* P. M.
on the date above stated.

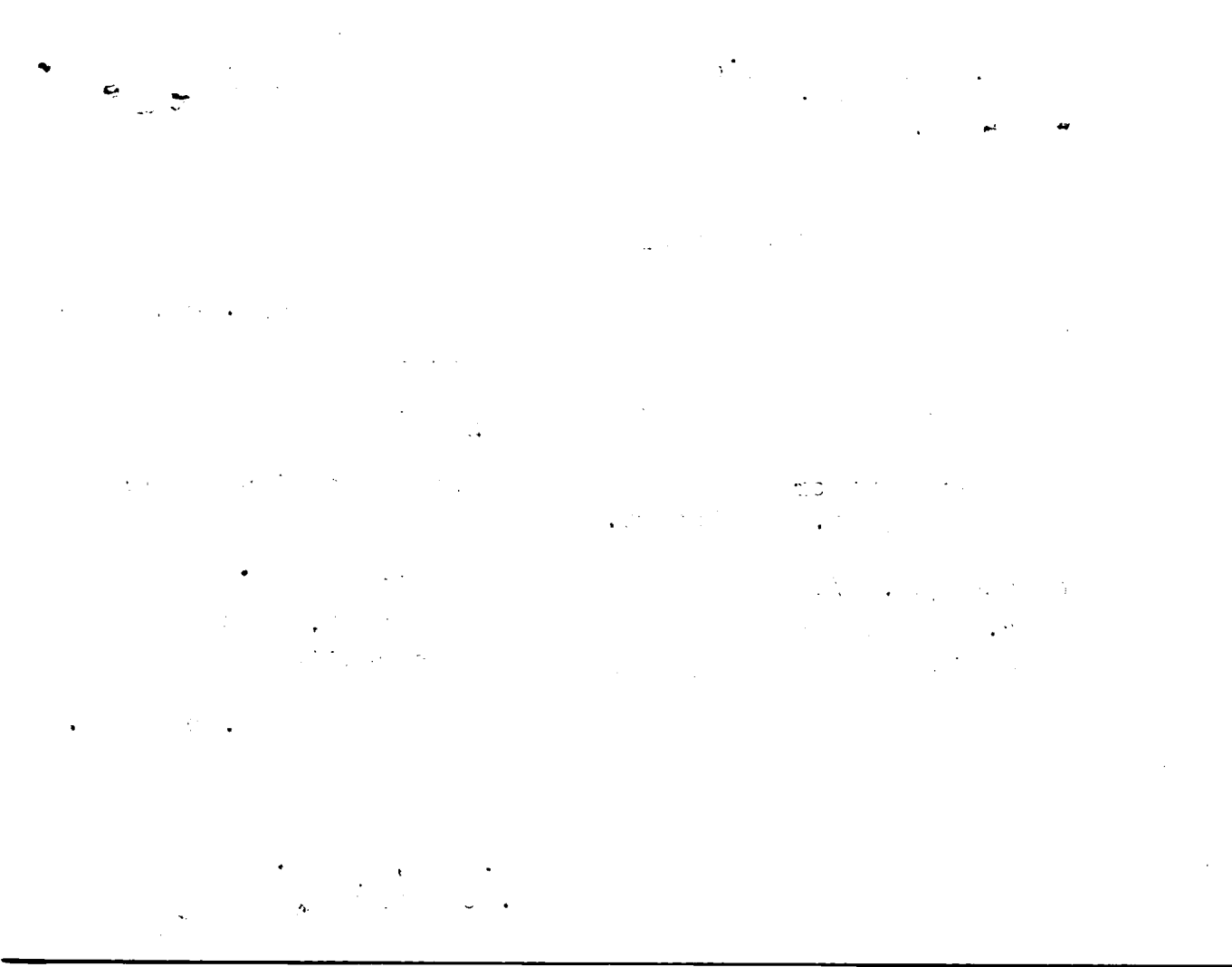
(Signature) *Henry H. Wheeler*

(Physician or Midwife)

Address *Ft. Hall, Idaho.*

Filed *Feb. 16 1929* *Allen Cutler* Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Delayed complete

STATE OF IDAHO

September 1938

RECEIVED MAR 8 1939

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

64869

PLACE OF DEATH

County of **Ft. Hall Reservation** CERTIFICATE OF DEATH

Idaho

Registration District No. **121**

City of

Primary Registration District No. **2194 R.**

Local Registrar's No. **27**

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME **Allen Cutler**

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

**Shoshone
Ind. 1/8**

5. Single, Married, Widowed,
or Divorced (write the word)

Single

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

)))

6. DATE OF BIRTH (month, day and year) **Sept. 30, 1928**

7. AGE

Years

Months

Days

If LESS than 1 day,

hrs. or
min.

0

0

0

0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.

Unborn

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) **Ft. Hall Reservation**
(State or country)

10. NAME OF FATHER

Andrew Cutler

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

Mo. Cammon, Idaho

12. MAIDEN NAME OF MOTHER

Esther Webber

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

Humbolt, Iowa.

14. Informant **Esther Cutler**

(Address) **Ft. Hall, Idaho**

15. Filed **Feb. 16, 1929** *W. L. L. & P. L. L.*

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 30

1928

Treated by **Dr. Howard, Pocatello, Ida.**

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19_____, to _____, 19_____,

that I last saw him alive on _____, 19_____,

and that death occurred, on the date stated above, at **11.15 Pm.**

The CAUSE OF DEATH* was as follows:

**Stillborn due to oversize of
child, (Monster)**

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? **NO** Date of _____

Was there an autopsy? **NO**

What test confirmed diagnosis? **Birth of Child**

(Signed) *Henry H. Wheeler* M. D.

(Address) **Ft. Hall, Idaho**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal
**Mountain View Cemetery
Pocatello, Idaho.**

Date of Burial

Oct. 4 19

20. Undertaker
Shoemaker & Beasley, Pocatello

Address

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF RECEIVED FEB 21 1928
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
COUNTY OF 2nd
CITY OF Darlington
No. 169-128-012-243 St. _____
(If born in hospital or institution
give name.)
Registration District No. 59 State File No. 168677
Prim. Registration District No. 2129 Local Registrar's No. 147

FULL NAME OF CHILD Victor Ferguson
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth (To be answered only in event of plural births)	Legitimate? <u>Yes</u>	Date of birth <u>Sept 28</u> 19 <u>25</u> (Month) (Day) (Year)
--------------------------	---	--	---------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 5 (a) Born alive and now living 4

Born alive but now dead 0 Stillborn 1

FATHER FULL NAME <u>Myron Ferguson</u>	MOTHER FULL MAIDEN NAME <u>Martha Buck</u>
---	---

Residence (Usual place of abode) Darlington Id

If nonresident, give place and State _____

Color or race White Age at last Birthday 38 (Years)

Birthplace Utah (City and State or Country)

Occupation Lawsonville

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 9:30 P. M.
on the date above stated.

(Signature) F. E. Barrett

Idaho
(Physician or midwife)

Address _____

Filed Oct. 5, 1928 J. V. Salt

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

MAY 22 1970

CHILD NAME OF CHILD

SEX OF CHILD

What prophylactic was used to prevent tetanus infection?

Number of child of this mother living in home at birth and now living

Born at what hospital?

MOTHER

DATE OF BIRTH

TIME OF BIRTH

Place of birth

At what hospital was the child born?

Color of face

Birthplace

Child was born at (Country)

IDENTIFICATION OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was (Stillborn)

on the date above stated.

Where there was no attending physician

or midwife, then the father, husband,

or other person who was present at the birth

shall sign and state the date of birth

above other witnesses of the birth.

Address

Phone

REG-1047

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25-M-1-16-13

1929

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129
(No. _____ St.)

File No. 64913
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Victor Jorgenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

RECEIVED
(Write the word)

6. DATE OF BIRTH.

Sept. 28 1928
(Month) (Day) (Year)

7. AGE

Died at birth

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

None

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Darlington, Idaho.

10. NAME OF FATHER

Myrvin Jorgenson

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Martha Bush

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) _____

(Address) _____

15.

Filed Oct. 5, 1928

J. T. Salt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 28 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 28 1928 to Sept 28 1928

that I last saw him alive on Sept 28 1928

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Strangulation as Deceased
was found
unable to Resuscitate
(Duration) _____ Yrs. _____ mos. 4 ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) T. E. J. Burnett M. D.

1928 1928 (Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....Yrs.....mos.....days In the State.....Yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

This was filed Oct. 5, but was incomplete until a few days ago

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as *fracture of skull*, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

261707 035- RECEIVED APR 4 1929
PLACE OF BIRTH
County of Blaine STATE OF IDAHO
City of Leurstown, Ida. DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH **S**
No. St Joseph St. Registration District No. 96 State File No. 169761
(If born in hospital or institution give name.) Prim. Registration District No. 1009 Local Registrar's No. _____
FULL NAME OF CHILD Stillbirth
(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>Yes</u>	Date of birth <u>July 7</u> (Month) (Day) (Year) <u>1928</u>
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What prophylactic was used to prevent Ophthalmia Neonatorum? _____

Number of child of this mother, including present birth 2nd (a) Born alive and now living _____

Born alive but now dead _____ Stillborn Yes

FULL NAME <u>Ray Swank</u>	FATHER	FULL MAIDEN NAME <u>Maudie Callison</u>	MOTHER
----------------------------	--------	---	--------

Residence (Usual place of abode) Clarkston Wn

If nonresident, give place and State _____

Color or race White Age at last Birthday 25
(Years)

Birthplace Pomeroy
(City and State or Country)

Occupation Farmer

If nonresident, give place and State _____

Color or race White Age at last Birthday 19
(Years)

Birthplace Idaho
(City and State or Country)

Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was Born alive Stillborn at _____ M.
on the date above stated.

(Signature) Paul W. Johnson

(Physician or midwife)

Address Leurstown Ida

Filed Aug 17 1928 Susan E. Bruce

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

704

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH RECEIVED APR 4 1929 STATE OF IDAHO
County of Ne. Ada DEPARTMENT OF PUBLIC WELFARE
City of Lewiston BUREAU OF VITAL STATISTICS
No. 1008-18 St. 238-221035-134
(If born in hospital or institution
give name.)
Registration District No. 96 State File No. S 169817
Prim. Registration District No. 1009 Local Registrar's No.

FULL NAME OF CHILD Stillborn

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>F</u>	Twins } and { Triplet } or other? } (To be answered only in event of plural births)	Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>9 - 21</u> <u>1928</u> (Month) (Day) (Year)
-----------------------	--	-----------------------------------	------------------------	---

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth 1 (a) Born alive and now living 0
Born alive but now dead 0 Stillborn 1

FATHER
FULL NAME Wm G Schreiber
Residence (Usual place of abode) 1108-1821 Lewiston
If nonresident, give place and State Idaho
Color or race W Age at last Birthday 21 (Years)
Birthplace N. Dak.
(City and State or Country)
Occupation Laborer

MOTHER
FULL MAIDEN NAME Mary L. Aldrich
Residence (Usual place of abode) 1108-18 St. Lewiston
If nonresident, give place and State Idaho
Color or race W Age at last Birthday 17 (Years)
Birthplace Oregon
(City and State or Country)
Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 1:20 P. M.
on the date above stated. Stillborn

(Signature) J. M. Lytle

(Physician or midwife)

Address Lewiston, Idaho

Filed Oct-4, 1928 Doris E Bruce
Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

2

2

2

2

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65439

PLACE OF DEATH
County of Myer
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009

Local Registrar's No. _____

(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bontia May Schrieber

(a) Residence. No. 1108 - 18th Street St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Stillbirth Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston Idaho
(State or country)

10. NAME OF FATHER Mr. Schrieber

11. BIRTHPLACE OF FATHER (city or town) Blue Grass
(State or Country) N. Dak.

12. MAIDEN NAME OF MOTHER Mary Lucinda Aldrich

13. BIRTHPLACE OF MOTHER (city or town) Lane Co
(State or Country) Oregon

14. Informant N. Aldrich
(Address) Lewiston Idaho

15. Filed Oct - 3, 1928 Dwain E. Prime
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 21 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw him _____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Pills from
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. L. C. M. D.
Date 9-21 1928 (Address) Lewiston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Gifford Idaho Date of Burial 19____

20. Undertaker Brown, N. C. Address Lewiston

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK.—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

256-208 035-395
PLACE OF RECEIVED APR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Blaine
City of Lewiston

No. 1504 Main St. Registration District No. 96 State File No. 169825

Hospital White Primary Registration District No. 1209 Local Registrar's No. S

FULL NAME OF CHILD Evelyn Jane Knoll
(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? and Number in order of birth 1 Legitimate? Yes Date of birth 9-8-1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Argyrol 20%

Number of child of this mother, including present birth 4 Number of child of this mother now living, including present birth 4

FATHER	MOTHER
FULL NAME <u>Chauncey Knoll</u>	FULL MAIDEN NAME <u>Josephine Lindsey</u>
RESIDENCE <u>Lewiston Idaho</u>	RESIDENCE <u>Lewiston Idaho</u>
COLOR <u>N</u> AGE AT LAST BIRTHDAY <u>30</u> (Years)	COLOR <u>N</u> AGE AT LAST BIRTHDAY <u>28</u> (Years)
BIRTHPLACE <u>Missouri</u>	BIRTHPLACE <u>Virginia</u>
OCCUPATION <u>Electric Worker</u>	OCCUPATION <u>St. W.</u>

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 945 M. on the date above stated. Stillborn

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report. 192

(Signature) E. J. White
(Physician or midwife)

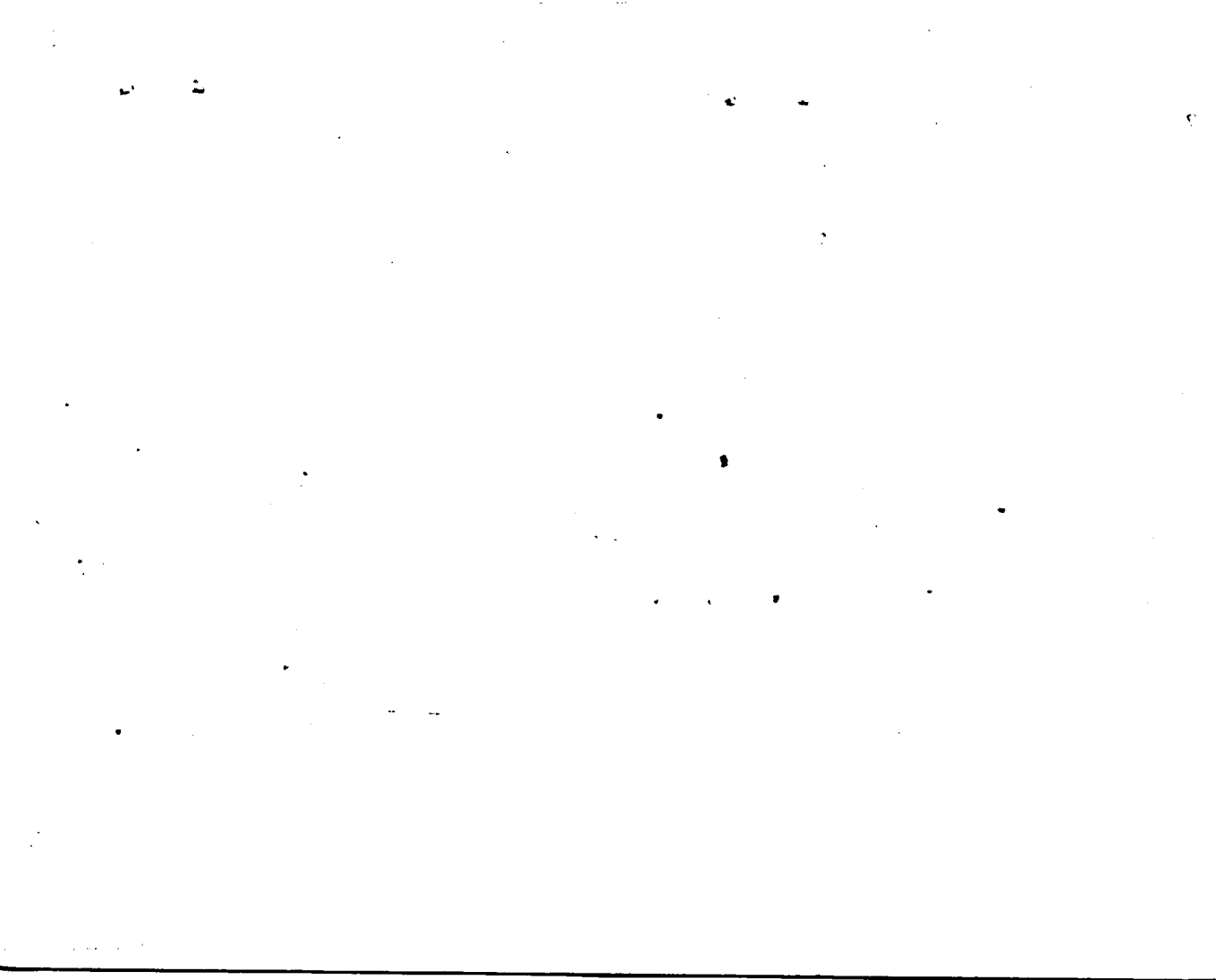
Address Lew. Ida.
Filed Oct-4 1928 Susan E. Bruce
Registrar. Registrar.

SEP 18 1945

Day

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD
N. B.--In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

795 111035-493
PLACE OF BIRTH RECEIVED APR 4 1928
STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
County of Regina
City of Regina
No. 1504 (Main) St. Registration District No. 96 State File No. 169852
Hospital White Primary Registration District No. 1009 Local Registrar's No. S
FULL NAME OF CHILD Stillborn Person
(Certificate of no value without full name of child)
Sex of Child Male Twin Triplet or other? and { Number in order of birth 1 Legitimate? Yes Date of birth 10-11-1928
(To be answered only in event of plural births) (Month) (Day) (Year)
What bactericidal solution was used in eyes? asepsol 2.0%
Number of child of this mother, including present birth 3 Number of child of this mother now living, including present birth 2
FATHER MOTHER
FULL NAME Harry Rufus Person FULL MAIDEN NAME Kirian B. Miles
RESIDENCE Clarksston Wash RESIDENCE Clarksston Wash
COLOR W AGE AT LAST BIRTHDAY 25 COLOR W AGE AT LAST BIRTHDAY 23
(Years) (Years)
BIRTHPLACE West Virginia BIRTHPLACE Oregon
OCCUPATION Barber OCCUPATION H.W.
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE
I hereby certify that I attended the birth of this child, who was Stillborn at 2.05 A. M.
on the date above stated.
{ *When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.
Give names added from a supplemental report.
192
Registrar. Address 10010 1928 Simon E Bruce Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 65466

PLACE OF DEATH
County of Naz Perce.
City of Lewiston.

Registration District No. 96
Primary Registration District No. 1009

Local Registrar's No. _____

(No. White hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stanley Pinson.

(a) Residence. No. _____ St. Clarkston, Washington.

(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male. 4. COLOR OR RACE White. 5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 10/11/28.

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nons.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston, Idaho.
(State or country)

10. NAME OF FATHER H. R. Pinson.

11. BIRTHPLACE OF FATHER (city or town) Cameron,
(State or Country) West Virginia.

12. MAIDEN NAME OF MOTHER Vivian B. Miller.

13. BIRTHPLACE OF MOTHER (city or town) Asotin,
(State or Country) Washington.

14. Informant W. P. Pinson.
(Address) Clarkston, Washington.

15. Filed Nov 10 1928 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 11th, 1928.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

that I last saw h_____ alive on _____, 19____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born
Signs of Cord.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

Unknown.

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) E. L. White, M. D.

10/11/28., 19____ (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston, Idaho. Date of Burial 10/12/28. 19____

20. Undertaker Brower-Wann Company. Address Lewiston, Idaho

4

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

819,111,035,897

PLACE OF BIRTH

County of Lewiston, Ida RECEIVED APR 4 1929

City of Lewiston, Ida

No. St. Joseph St.

(If born in hospital or institution
give name.)

Registration District No. 96 State File No. S 169869

Prim Registration District No. 1009 Local Registrar's No. 1009

FULL NAME OF CHILD (Stillbirth) Harris

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child <u>Male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth	Legiti- mate? <u>yes</u>	Date of birth <u>Nov- 11</u> (Month) (Day) (Year) <u>19 28</u>
--------------------------	---	--------------------------------------	-----------------------------	--

What prophylactic was used to prevent Ophthalmia Neonatorum? None

Number of child of this mother, including present birth 2 (a) Born alive and now living None

Born alive but now dead None Stillborn 2

FATHER FULL NAME <u>Luy E. Harris</u>	MOTHER FULL MAIDEN NAME <u>Mabel Higley</u>
--	--

Residence (Usual place of abode) Lewiston, Ida Residence (Usual place of abode) Lewiston, Ida

If nonresident, give place and State Idaho If nonresident, give place and State Idaho

Color or race White Age at last Birthday 29 Color or race White Age at last Birthday 27
(Years) (Years)

Birthplace Idaho Birthplace Washington
(City and State or Country) (City and State or Country)

Occupation Electrician Occupation Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Stillborn at 10:40 P M.
on the date above stated.

(Signature) Paul W. Johnson

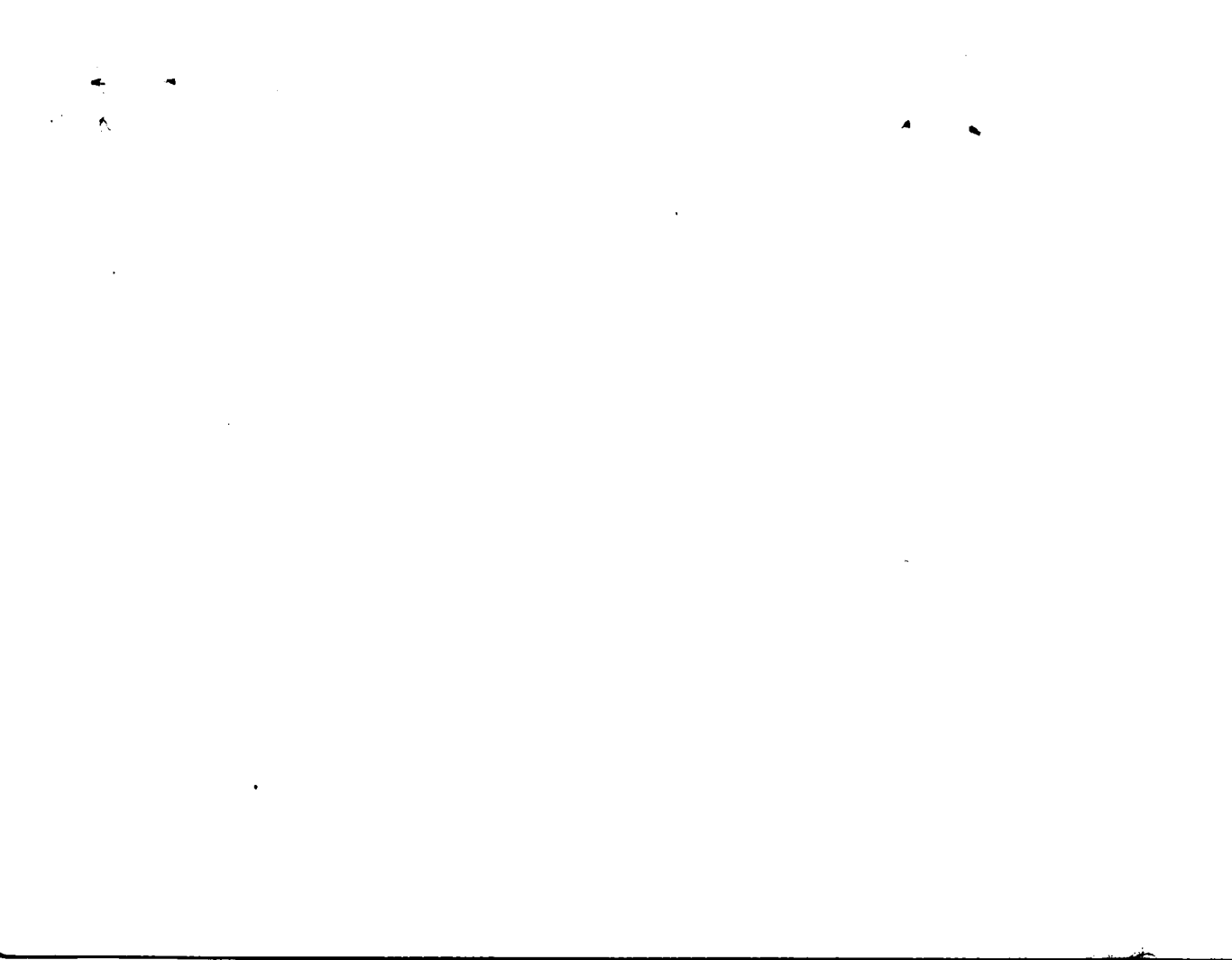
(Physician or midwife)

Address Sumner E. Brown

Filed Dec 7 19 28 Sumner E. Brown

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.



PLACE OF DEATH

County of Myresce
City of LewistonSTATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 96Primary Registration District No. 1009(No. St Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 65512

Local Registrar's No. _____

2. FULL NAME Baby Harris

(a) Residence. No. _____ St. _____

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OF RACE White 5. Single Married, Widowed, or Divorced (write the word) Single5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of _____6. DATE OF BIRTH (month, day and year) Premature7. AGE Years Months Days If LESS than 1 day, hrs. or min. Premature

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) Infant.

(c) Name of employer _____

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho10. NAME OF FATHER Guy Harris11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho12. MAIDEN NAME OF MOTHER Mabel E. Higby13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash14. Informant Guy Harris
(Address) Lewiston Idaho15. Filed Dec 10, 1928 Ernest E. Bruce
RegistrarMEDICAL CERTIFICATE OF DEATH 20616. DATE OF DEATH Nov 12 1928
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 12, 1928 to Nov 12, 1928that I last saw him alive on Still born, 19____
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

Still birth, died him dead about 4 or 5 days. Cause of Death was nephritis in the mother.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18. Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Paul Johnson M. D.Nov 19, 1928 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho Date of Burial Nov 12 192820. Undertaker Passes Mortuary Lewiston Idaho Address _____

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: Farmer (retired 6 yrs.) For persons who have no occupation whatever, write None.

STATEMENT OF CAUSE OF DEATH.—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebro-

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fractured skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

695 700 035 419

PLACE OF RECEIVED APR 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

CERTIFICATE OF BIRTH 169874

County of W. Peace

City of Lewiston

No. 1302 Main St. Registration District No. 96 State File No. _____

Hospital White Primary Registration District No. 1009 Local Registrar's No. _____

FULL NAME OF CHILD Ragnvald Fredrickson

(Certificate of no value without full name of child)

Sex of Child Male Twin Triplet or other? _____ and { Number in order of birth _____ } Legitimate? Yes Date of birth 11 20 1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? Argent 20%

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth 0

FATHER
FULL NAME Eritz Fredrickson
RESIDENCE 1302 Main Lewiston
COLOR White AGE AT LAST BIRTHDAY 28 (Years)
BIRTHPLACE Norway
OCCUPATION Labor

MOTHER
FULL MAIDEN NAME Elia Martinson
RESIDENCE White
COLOR Norway AGE AT LAST BIRTHDAY 30 (Years)
BIRTHPLACE Hadselwike
OCCUPATION _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was { Born alive } Stillborn { at 11:15 A. M. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) E. L. White MD

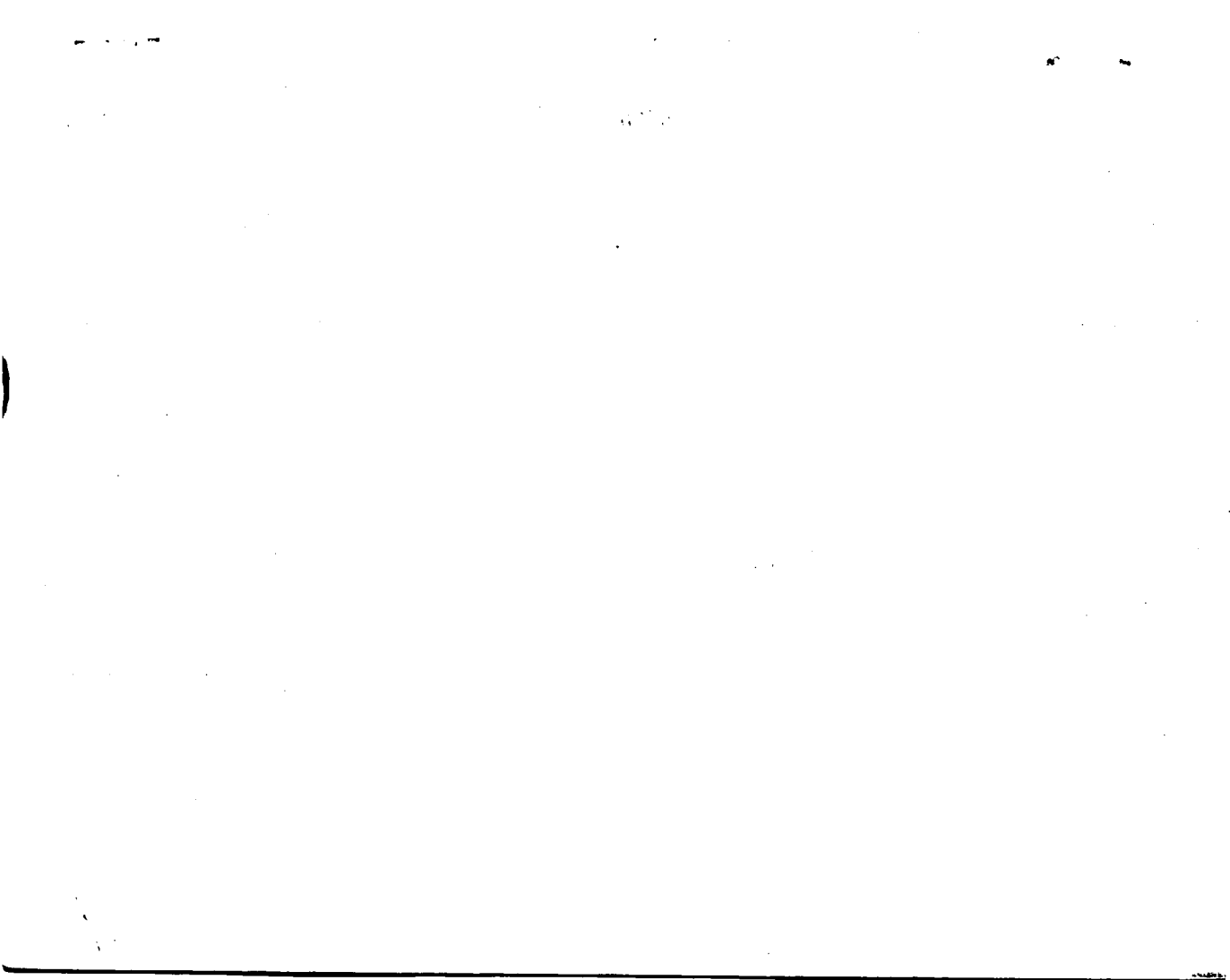
(Physician or midwife)

Address City

Filed Dec 7 1928 Doris E. Bruce

Registrar.

Registrar.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1929

PLACE OF DEATH

County of *My Perce*

City of *Lewiston*

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. *96*

Primary Registration District No. *1009*

(*No. Write Hospital*)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME *Baby Fredrickson* *9'*

(a) Residence. No. *1302 Main* St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX *M* 4. COLOR OR RACE *White* 5. Single, Married, Widowed, or Divorced (write the word) *Single*

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

☒ AGE *Stillborn* Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

10. NAME OF FATHER *Fritz Fredrickson*

11. BIRTHPLACE OF FATHER (city or town) (State or Country) *Norway*

12. MAIDEN NAME OF MOTHER *E. Lisa Martensen*

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) *Norway*

14. Informant *Fritz Fredrickson* (Address) *1302 Main Lewiston Ida*

15. Filed *Dec 10*, 19*28* *Susan E Bruce* Registrar

DO NOT WRITE IN THIS SPACE

State File No. *65505*

Local Registrar's No.

MEDICAL CERTIFICATE OF DEATH *906*

16. DATE OF DEATH

11 - 20 19*28*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10 - 20, 19*28* to *11 - 20*, 19*28*
that I last saw him alive on *still born*, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Unknown Cause

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Unknown Cause

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *Did at least two days*

What test confirmed diagnosis? *before birth*

(Signed) *E. L. White*, M. D.

11-21, 19*28* (Address) *Lewiston Ida*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal *Lewiston Idaho* Date of Burial *11-21 1928*

20. Undertaker *Bronner & Hann Co* Address *Lewiston Ida*

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebro-**

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS**, state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS.—Mail all death certificates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical

statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH		STATE OF IDAHO	
County of <u>Valley</u>		DEPARTMENT OF PUBLIC WEFARE	
City of <u>RECEIVED</u>		BUREAU OF VITAL STATISTICS	
		70146	
No. <u>292-117043-292</u>		CERTIFICATE OF BIRTH	
St. <u>292-117043-292</u>		Registration District No. <u>15</u> State File No. <u>15</u>	
(If born in hospital or institution give name.)		Prim. Registration District No. <u>15</u> Local Registrar's No. <u>15</u>	
FULL NAME OF CHILD <u>Billy Cleveland Kibbey</u>		(If stillborn, substitute the word "Stillborn" for name of child)	
Sex of Child <u>male</u>	Twin Triplet or other? <u>no</u> } and { Number in order of birth <u>1</u>	Legitimate? <u>yes</u>	Date of birth <u>Dec. 17</u> 19 <u>28</u> (Month) (Day) (Year)
What prophylactic was used to prevent Ophthalmia Neonatorum <u>Erythromycin</u>			
Number of child of this mother, including present birth <u>4</u> (a) Born alive and now living <u>3</u>			
Born alive but now dead <u>1</u> Stillborn <u>0</u>			
FATHER FULL NAME <u>W. C. Kibbey</u>		MOTHER FULL MAIDEN NAME <u>Eva Kibbey</u>	
Residence (Usual place of abode) <u>reside</u>		Residence (Usual place of abode) <u>reside</u>	
If nonresident, give place and State <u>no</u>		If nonresident, give place and State <u>no</u>	
Color or race <u>white</u> Age at last Birthday <u>43</u> (Years)		Color or race <u>white</u> Age at last Birthday <u>41</u> (Years)	
Birthplace <u>Keokuk, Iowa</u> (City and State or Country)		Birthplace <u>Iowa</u> (City and State or Country)	
Occupation <u>laborer</u>		Occupation <u>laborer</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was (Born alive) at 5 P. M. on the date above stated.

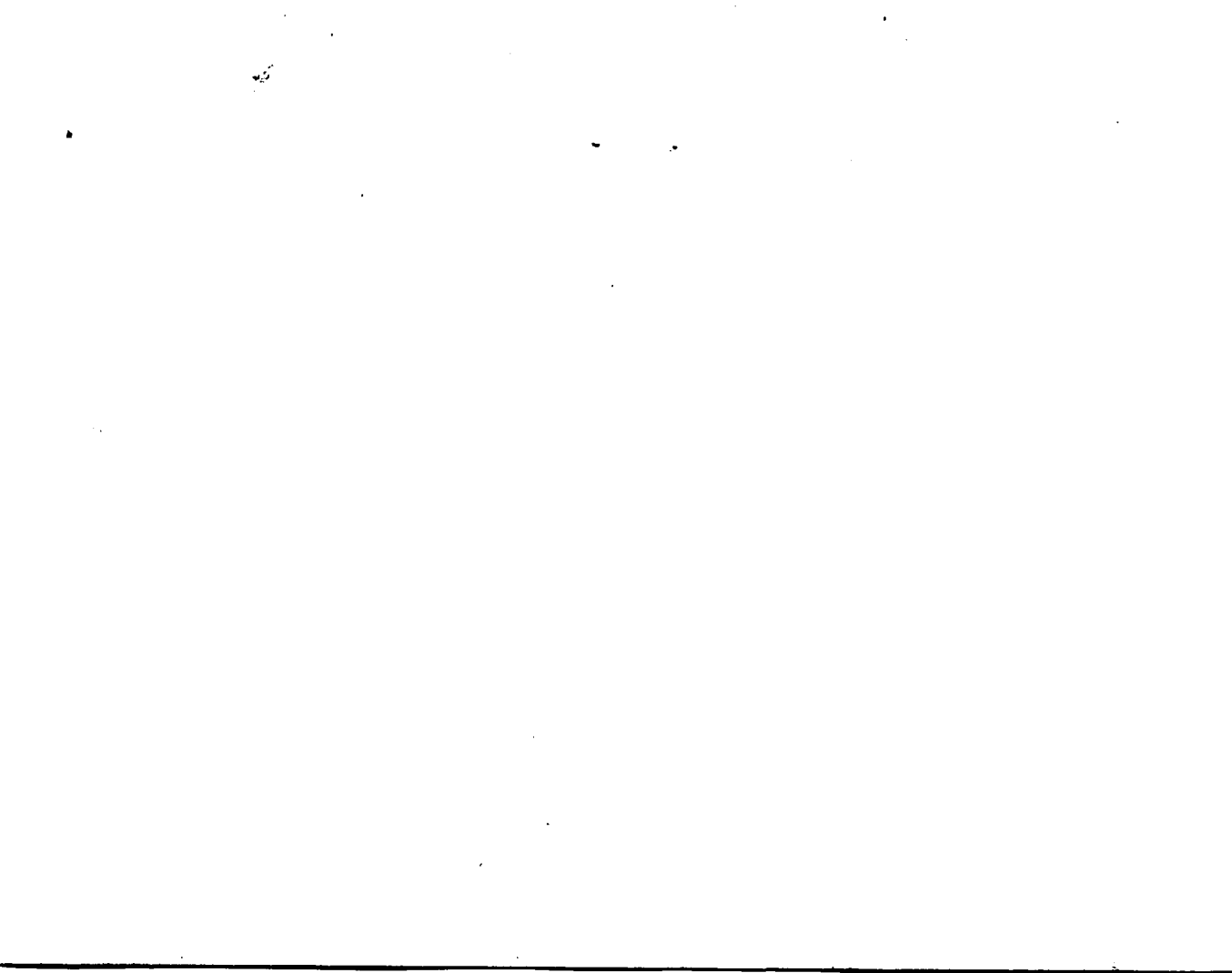
(Signature) W. G. Olson

(Physician or midwife)

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Address Stella Cain

Filed 19 Registrar.



WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

PLACE OF BIRTH MAY 4 1929

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

S

County of Bannock

City of Grace

No. 519-221-003-263 St. Registration District No. 84 State File No. 170225

Hospital Primary Registration District No. 2161 Local Registrar No. 643

FULL NAME OF CHILD Rae Pearl Constance Carl

(Certificate of no value without full name of child)

Sex of Child Female Twin Triplet or other? and { Number in order of birth Legitimate? Yes Date of birth June 21 1928
(To be answered only in event of plural births) (Month) (Day) (Year)

What bactericidal solution was used in eyes? AgNO₃ 1%

Number of child of this mother, including present birth 2 Number of child of this mother now living, including present birth

FATHER
FULL NAME Horace Wilson Carl
RESIDENCE Grace Ida

MOTHER
FULL MAREN NAME Lawn Bollwinkel
RESIDENCE Grace Ida

COLOR White AGE AT LAST BIRTHDAY 26
(Years)

COLOR White AGE AT LAST BIRTHDAY 30
(Years)

BIRTHPLACE Farmington, Utah

BIRTHPLACE Thatcher Ida

OCCUPATION Field agent

OCCUPATION Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was born alive at 7:30 A. M.
on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Give names added from a supplemental report.

(Signature) Joseph E. Otte

(Physician or midwife)

Address Grace Ida

Filed Apr 30 1929 Mrs. E. E. Fitt

Registrar.

Registrar.

No 9

819-124.001-619
PLACE OF BIRTH

Form V. S. No. 11-20m-7-36-19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

County of AdaCity of Boise

Registration District No. _____

File No. S 170974

No. _____ St. _____

Hospital St. Alphonsus

Primary Registration District No. _____

Registered No. 220FULL NAME OF CHILD Stillborn (5 $\frac{1}{2}$ mo. foetus)

Sex of Child <u>Male</u>	<u>Twin</u> Triplet or other? (To be answered only in event of plural births)	and	<u>Number</u> in order of birth	Legiti- mate? <u>Yes</u>	Date of Birth <u>May 24</u> <u>1929</u> (Month) (Day) (Year)
--------------------------	--	-----	---------------------------------------	-----------------------------	---

FULL NAME FATHER
George HarrisRESIDENCE
Parma, IdahoCOLOR white AGE AT LAST BIRTHDAY 37
(Years)BIRTHPLACE
Eagle, IdahoOCCUPATION
FarmerFULL MAIDEN NAME MOTHER
Elizabeth FarleyRESIDENCE
Parma, IdahoCOLOR White AGE AT LAST BIRTHDAY 37
(Years)BIRTHPLACE
Vale, OregonOCCUPATION
Housewife

Number of child of this mother, including present birth. _____ Number of children of this mother now living, including present birth. _____

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was stillborn at 12:15 am M.
on the date above stated.

(Born alive or stillborn)

*When there was no attending physician or midwife then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

(Signature) W. H. Rhoades

Physician

(Physician or midwife)

Given names added from a supplemental report. _____

Boise, Idaho

Address _____

Filed 5/2719 29W. H. Rhoades

Registrar.

Registrar.

N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

UNITED STATES DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
BUREAU OF VITAL STATISTICS
Form No. 23 (Rev. 1-1-60)
This form is to be filled out by the physician or midwife attending the birth of the child.
It should be filled out as soon as possible after the birth of the child.

Form No. 23 (Rev. 1-1-60)

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF BIRTH

Registration District No. _____
Hospital _____
Registered No. _____

FULL NAME OF CHILD _____
Sex of Child _____

DATE OF BIRTH _____
TIME OF BIRTH _____
PLACE OF BIRTH _____

FATHER'S NAME _____
MOTHER'S NAME _____
RESIDENCE _____

AGE AT LAST BIRTHDAY _____
COLOR _____
BIRTHPLACE _____

OCCUPATION _____
BIRTHPLACE _____

Number of child of this mother including present birth _____
CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE

I hereby certify that I attended the birth of this child, who was _____
born on the _____ day of _____, 19____.

Signature of Physician or Midwife _____
Name of Physician or Midwife _____

Signature of Registrar _____
Name of Registrar _____

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for
each and the number of each, in order of birth stated.

799-122-014-413
PLACE OF BIRTH
RECEIVED OCT 9 - 1929
County of Camden
City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF BIRTH

S

No. _____ St. _____

Registration District No. 7

State File No. 174813

(If born in hospital or institution
give name.)

Prim. Registration District No. 1006 Local Registrar's No. 23

FULL NAME OF CHILD Frank William, Jr.

(If stillborn, substitute the word "Stillborn" for name of child)

Sex of Child <u>male</u>	Twin Triplet or other? (To be answered only in event of plural births)	and { Number in order of birth (To be answered only in event of plural births)	Legiti- mate? <u>yes</u>	Date of birth <u>July 22</u> (Month) (Day) (Year) <u>1928</u>
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What prophylactic was used to prevent Ophthalmia Neonatorum? argyrol

Number of child of this mother, including present birth 6 (a) Born alive and now living 5

Born alive but now dead _____ Stillborn 1

FATHER
FULL NAME Frank William Guinn

MOTHER
FULL MAIDEN NAME Bettie R. Mathews

Residence (Usual place of abode) R 2

Residence (Usual place of abode) R 2

If nonresident, give place and State _____

If nonresident, give place and State _____

Color or race W Age at last Birthday 45
(Years)

Color or race W Age at last Birthday 40
(Years)

Birthplace Alexander, Neb.
(City and State or Country)

Birthplace Daykin, Neb.
(City and State or Country)

Occupation farmer

Occupation farmer

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was {Born alive} at 6:00 P. M.
on the date above stated. {Stillborn}

(Signature) Chas E Mangum

Physician
(Physician or midwife)

Address Nampa, Ida.

Filed 10-7 1929 Seith Conway

Registrar.

*Where there was no attending physician
or midwife, then the father, householder,
etc., should make this return. A stillborn
child is one that neither breathes nor
shows other evidence of life after birth.

THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 58TH STREET
CHICAGO, ILL. 60637

1. WILLIAM LEE 1717-1764.19 SEPTEMBER
died at his home and was buried in the
grave to which he had been taken

approximately 1000000 on 21/2/2000. The
rehabilitation project will involve the
restoration of the site and the surrounding
area to a natural condition and the
protection of the site from further
development.

1941 (1941-1942) 1941 (1941-1942)

CONFIDENTIAL - SECURITY INFORMATION

1. The first step is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

...the ...

1000

1992-1993

4752

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

42 24 31

147 344 STADNITSE

STATE OF NEW YORK

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of BlaineRegistration District No. 7City of NampaPrimary Registration District No. 1006(No. Nazarene Hospital)State File No. 62452Local Registrar's No. 87

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant son of Mrs. F. W. Guinn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single
(Write the word)

6. DATE OF BIRTH

July 22 1928
(Month) (Day) (Year)

7. AGE

1 Yrs. 4 Mos. 6 ds.IF LESS than 1 day how many
4 hrs. or
4 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Nampa Idaho

10. NAME OF Father

Frank W. Guinn

11. BIRTHPLACE OF FATHER

(State or Country)

Albion Neb.

12. MAIDEN NAME OF MOTHER

Nattie Mathews

13. BIRTHPLACE OF MOTHER

(State or Country)

Dakota Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Nampa Idaho R #3

15.

Filed

7-419 28Mae Kerby
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 22 1928
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

19. to 19.

that I last saw h. alive on 19.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Mangum M. D.7/31/1928 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. days. State yrs. mos. ds.Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mary's Cemetery 7-23 1928

20. UNDERTAKER

ADDRESS

Tracy R. R. R. Nampa

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) **Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer, etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid Housekeepers, who receive a definite salary), may be entered as **Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home.** If the occupation has been changed or given up on account of the **DISEASE CAUSING DEATH**, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH.—Name, first the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same

accepted term for the same disease. Examples: **Cerebro-spinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia") **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Carcoma, etc., of** (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "**PUERPERAL septicemia,**" "**PUERPERAL peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For **VIOLENT DEATHS** state **MEANS OF INJURY** and qualify as **ACCIDENTAL, SUICIDAL, or HOMICIDAL**, or as probably such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fracture of skull, and consequences (e. g. sepsis, tetanus) may be stated under the head of "Contributory."

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—In case of more than one child at birth a SEPARATE RETURN must be made for each and the number of each, in order of birth stated.

PLACE OF BIRTH

County of

City of

No.

St.

212-206-024-751

(If born in hospital or institution give name.)

Registration District No.

State File No.

Prim. Registration District No.

Local Registrar's No.

FULL NAME OF CHILD

(If stillborn, substitute the word "Stillbirth" for name of child)

Sex of Child

Female

Twin
Triplet
or other?
(To be answered only in event of plural births)

and { Number
in order
of birth

5th

Legiti-
mate?

yes

Date of
birth

Nov 6

1928

What prophylactic was used to prevent Ophthalmia Neonatorum?

Number of child of this mother, including present birth

(a) Born alive and now living

Born alive but now dead

Stillborn

FULL
NAME

Ira A Kassens

FULL
MAIDEN
NAME

Bessie Pearson

Residence (Usual place of abode)

Wendell

Residence (Usual place of abode)

Wendell

If nonresident, give place and State

If nonresident, give place and State

Color or race

White

Age at last Birthday

49

Color or race

W

Age at last Birthday

38

Birthplace

Indiana

Birthplace

Utah

Occupation

Farmer

Occupation

Housewife

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was

Born alive

Stillborn

at

6 P. M.

on the date above stated.

(Signature)

E. L. Sinnott

Physician or midwife

Address

Wendell Ida

Filed

4-30-1930

E. L. Sinnott

Registrar.

*Where there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

4017